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Obamacare Interrupted: Obstructive Federalism and the Consumer Information Blockade

KATHERINE T. VUKADIN[†]

*I deem [one of] the essential principles of our
Government . . . the diffusion of information.¹*

INTRODUCTION

The Affordable Care Act (“ACA”)² aims to deliver cost-effective health insurance to Americans while decreasing the cost of care and improving outcomes. These aspirations mean little, however, unless accurate information about the ACA reaches its key stakeholders: consumers.

The ACA allows the states to embrace or reject some of the law’s most significant tenets; one widely-criticized rejection is the southern states’ refusal to expand Medicaid. Less well known and little criticized, however, is the quiet

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1. Thomas Jefferson, First Inaugural Address (Mar. 4, 1801), *available at* http://avalon.law.yale.edu/19th_century/jefinau1.asp.

2. The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of U.S.C.), was signed into law on March 23, 2010; the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of U.S.C.), was signed into law on March 30, 2010. These two bills will be referred to as the Affordable Care Act (ACA) or the Act in this Article, and, for the ease of the reader, all citations will be to the final ACA bill if possible.

rejection of a second, equally significant underpinning of the ACA: informational transparency for consumers. The ACA contains a network of provisions designed to revolutionize health insurance by permitting previously-unknown information to flow freely. Provision after provision of the ACA reflects a deep-seated faith in the role of information dissemination and collection, which permits informed consumer choices and targeted enforcement of consumer protections. The states can, however, opt out of many consumer information provisions. At the same time, the states cannot opt out of the federally-implemented individual and employer mandates and the associated penalties; these penalties remain a constant, applying equally to every American regardless of state recalcitrance.

This Article posits that the states rejecting the ACA's consumer information provisions are thereby relegating their citizens to a second-class ACA status, in which the ACA's penalties apply but the benefits remain elusive. Under those states' obstructive federalism approach, their citizens remain subject to the ACA's federal costs and penalties but their access to health insurance is threatened by lack of information. While some of the provisions have a federal fallback, the federal government is ill-equipped to take on the full burden of implementation, and federal intrusion is particularly unwelcome in these states. So that the ACA's benefits are more consistently available to Americans of every state, citizens and policy-makers in recalcitrant states should advocate for informational transparency and full information for consumers, just as stakeholders are pushing for the Medicaid expansion in those states. While a federal fallback exists for some aspects of the ACA, the effective provision of consumer information requires state participation and should not be ceded to the federal government.

Part I summarizes the ACA's goals and the informational transparency provisions designed to help accomplish the goals; Part II explains certain states' obstructive federalism and how these states are ignoring or undermining the ACA's transparency provisions; and Part III describes the perverse, secondary results of this rejection and possible means of ameliorating these outcomes.

I. THE ACA'S GOALS AND INFORMATIONAL TRANSPARENCY

The ACA aims to increase health insurance enrollment and improve healthcare costs and outcomes. Controversial from the start, the law's passage required a cooperative federalism approach,³ by which the federal government and the states would each have significant roles. Alongside this commitment to cooperative federalism, the ACA reflects its drafters' belief in the power of informational transparency to accomplish a variety of health insurance and healthcare goals. The ACA's success depends on cooperative federalism and the free flow of information.

A. *A Foundation in Informational Transparency*

The ACA employs informational transparency to accomplish goals extending from improved access to affordable health insurance to better public health through disclosure of nutritional information. Provision after provision calls for the gathering, disclosure, or exchange of information. This emphasis on informational transparency stems from the ACA's drafters' faith in the power of information's free flow to bring about health reform.⁴ The drafters envisioned informational transparency operating at

3. See *infra* Part II.A.

4. Bending the curve of healthcare costs and enhancing information sharing “will first require the administration and private parties to work together to exchange real-time information to support care and also to enable better measurement of cost and quality of care at the individual-level, empowering specific clinical transformation efforts.” Joseph Antos, et al., *Bending the Curve Through Health Reform Implementation*, 16 AM. J. MANAGED CARE 804, 808 (2010). ACA architect Ezekiel Emanuel, M.D., Ph.D., referred to transparency as an “imperative,” so that patients can learn about the cost of healthcare services and the quality of the providers before undergoing treatment. Robert P. Kocher & Ezekiel J. Emanuel, *The Transparency Imperative*, 159 ANNALS INT’L MED. 296, 296 (2013) (“All data on price, utilization, and quality of health care should be made available to the public unless there is a compelling reason not to do so.”). At present, patients have tremendous difficulty finding out the price of a procedure in advance—“obtaining such information is almost impossible.” *Id.* In addition, Kocher and Emanuel argue that to make an informed decision about whether and with whom to have a procedure, patients need to know how many such procedures a potential provider has performed. *Id.* (“Physician case volume is one of the most important predictors of quality for many surgeries and medical conditions.”).

numerous levels; the ACA reflects this vision, with transparency of information for healthcare prices,⁵ health insurance value information, and insurance price increase information.⁶ And, where relationships and the exchange of money and gifts can influence decision-making, those relationships and exchanges should be disclosed.⁷

But informational transparency in the ACA is much broader than that. As described below, the ACA includes transparency provisions designed to connect consumers with their benefits, enforcement officials with appropriate targets, and the public with information about health insurance pricing practices.

B. How Informational Transparency Accomplishes the ACA's Main Goals

Informational transparency provisions help consumers access the information necessary to claim their rights, while other provisions call for the disclosure of information to shed light on less desirable practices and relationships. While some of the informational transparency provisions operate without state assistance, others count the state governments as first-line implementers.

5. Ezekiel J. Emanuel, *In Health Care, Choice Is Overrated*, N.Y. TIMES (Mar. 5, 2014), http://www.nytimes.com/2014/03/06/opinion/in-health-care-choice-is-overrated.html?_r=0 (“[W]e need more transparency. Insurance companies should have to publish the measures they use to select their ‘high performing’ or ‘efficient’ networks. This will discourage them from looking at price alone.”); Ezekiel Emanuel et al., *A Systemic Approach to Containing Healthcare Spending*, 367 NEW ENG. J. MED. 949 (2012).

6. Early in the health care reform discussions, ACA architect and Senate Finance Committee Chairman Max Baucus (D-Mont.) argued that transparency should be a key part of the proposed law. SEN. MAX BAUCUS, CALL TO ACTION: HEALTH REFORM 2009 69-70 (2008), available at <http://www.finance.senate.gov/download/?id=916b0ea3-96dc-4c7a-bb35-241fa822367e>. He envisioned transparency extending to the price of health insurance, including employer plans, and outcome information. See *id.* at 65.

7. *Id.* at 70.

1. Affordable, Available Health Insurance Through Exchanges, Outreach, and Education

The ACA aims to make high-quality, affordable health insurance more available and to bring immediate improvements to all health care coverage.⁸ With the full Medicaid expansion as originally planned, the ACA would have covered thirty-two million of the previously-uninsured,⁹

8. See ACA Title I. As enacted and if fully implemented, the ACA would have covered 32 million of the 50 million Americans without health insurance. J. Angelo DeSantis & Gabriel Ravel, *The Consequence of Repealing Health Care Reform in Early 2013*, 60 CLEV. ST. L. REV. 365, 376 (2012). Of those left without insurance, 19 million would be non-elderly adults, as follows:

Thirty-seven percent—mostly young singles without dependents—would be eligible for Medicaid, but not enrolled; Twenty-five percent would be undocumented immigrants; Sixteen percent would be exempt from the individual mandate because they would not have an affordable insurance option; Eight percent would be eligible for affordable subsidized coverage in the health benefit exchanges; The remaining 15 percent—most higher-income families with dependents—would likely be subject to the mandate, having an affordable private insurance option despite not qualifying for a subsidy.

MATTHEW BUETTGENS & MARK A. HALL, ROBERT WOOD JOHNSON FOUND., WHO WILL BE UNINSURED AFTER HEALTH INSURANCE REFORM? (2011), *available at* <http://www.rwjf.org/en/research-publications/find-rwjf-research/2011/03/who-will-be-uninsured-after-health-insurance-reform.html>. In 2010, about 16.3% of the U.S. population, or 49.9 million people, had no health insurance coverage. OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, DEP'T OF HEALTH & HUMAN SERVS., ASPE ISSUE BRIEF: OVERVIEW OF THE UNINSURED IN THE UNITED STATES: A SUMMARY OF THE 2011 CURRENT POPULATION SURVEY 1-2 (2011), *available at* <http://aspe.hhs.gov/health/reports/2011/CPSHealthIns2011/ib.pdf>.

9. JOHN E. McDONOUGH, INSIDE NATIONAL HEALTH REFORM 109-10 (Univ. of Cal. Press 2011). The ACA was never intended to provide universal coverage; even if fully implemented, the ACA would leave millions uninsured. Mark A. Hall, *Evaluating the Affordable Care Act: The Eye of the Beholder*, 51 HOU. L. REV. 1029, 1033 (2014) (citing Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives (Mar. 20, 2010), *available at* <http://www.cbo.gov/sites/default/files/amendreconprop.pdf>). The letter provides Congressional Budget Office ("CBO") and Joint Committee on Taxation ("JCT") estimates that by 2019, the combined effect of enacting H.R. 3590 and the reconciliation proposal would be "to reduce the number of nonelderly people who are uninsured by about 32 million, leaving about 23 million nonelderly residents uninsured (about one-third of whom would be unauthorized immigrants). Under the legislation, the share of legal nonelderly residents with insurance coverage would rise from about 83 percent currently to about 94 percent." Elmendorf, *supra*, at 9.

while bringing down the cost of both health insurance and health care itself.¹⁰ The ACA uses a multi-pronged approach to accomplish these goals, relying on mechanisms enacted directly as part of the ACA as well as indirect mechanisms, enacted as part of the ACA but then implemented through financial incentives to the states. One principal strategy for making health insurance more affordable is the ACA's direct financial support to lower income Americans. The ACA provides premium reductions¹¹ and also cost sharing subsidies,¹² available at income levels of up to 400% of the federal poverty level.¹³ So that lower income Americans are more able to afford health insurance, the ACA provides payments directly to insurers.¹⁴ Premium subsidies provide a tax credit for lower-income Americans who purchase health

10. See McDONOUGH, *supra* note 9, at 109-10, 176-77.

11. Individuals are eligible for the premium tax credits if:

(1) they are not eligible for employer-provided coverage or for a public health insurance program; (2) they are US citizens or lawful residents of the United States; (3) they are not incarcerated; and (4) their modified AGI is 100-400 percent of poverty (about \$11,500-\$46,000 for an individual and \$23,000-\$94,000 for a family of four in 2013). Lawfully present immigrants with incomes below 100 percent of poverty are also eligible if they do not qualify for Medicaid because of immigration status (for example, if they arrived in the United States during the past five years). To be eligible, individuals must file a federal tax return in 2015 (a joint return if married) and not be claimed as a dependent on anyone else's return. The premium tax credit can be used to purchase coverage for all people claimed as dependents on the tax return.

Julia James, *Health Policy Brief: Premium Tax Credits*, HEALTH AFFAIRS, 2-3 (Aug. 1, 2013) [hereinafter James, *Premium Tax Credits*], http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=97.

12. Out-of-pocket costs are subsidized for lower-income families. If a family of four earns between 100 and 150% of the federal poverty level, the family is responsible for paying 6% of covered expenses out-of-pocket, as compared with the 30% that a non-subsidized family would pay. If the family earns more—between 200 and 250% of poverty—then out-of-pocket spending is capped at \$2,250 for individuals and \$4,500 for family coverage, as opposed to the \$6,350, for individuals, or \$12,700, for families, for non-subsidized coverage. ACA §§ 1401-02.

13. *Id.* § 1401 (codified at I.R.C § 36B (2012)); § 1402(b)(2).

14. *Id.* § 1402(c)(3)(A).

insurance, and cost sharing subsidies limit the amounts that lower income Americans pay out of pocket for health care.¹⁵

Several provisions ensure that consumers receive good value when they purchase health insurance. To be considered a “qualified health plan,” meaning a plan that can be offered on an exchange, a health plan must include certain minimum coverage provisions.¹⁶ And, through new medical loss ratio rules, an insurer must refund premium dollars to insured persons if the company spends less than 85 or 80% of premiums on medical-related expenses—in addition, companies must report their medical loss ratio to the Department of Health and Human Services (“HHS”) and to the public.¹⁷ The ACA also makes health insurance more available by ensuring that Americans are not refused health insurance due to pre-existing conditions and that prices are not increased on the basis of gender or on any other basis except those specified.¹⁸ In addition, health insurance issuers must accept all individuals and employers who apply.¹⁹ Young adults can remain covered on a parent’s health insurance until age twenty-six.²⁰

Transparency and consumer outreach are important means of accomplishing these goals. Consumer outreach

15. *See id.* § 1402; *see also* McDONOUGH, *supra* note 9, at 124 (“Premium subsidies are needed so that the cost of purchasing health insurance does not take too much out of a family’s household budget. It’s not good enough, though, to reduce premiums to an affordable level if the coverage requires co-payments, deductibles, or co-insurance that prevents individuals and families from obtaining necessary medical care.”).

16. The services required to be covered include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventative and wellness services and chronic disease management, pediatric services, including oral and vision care. ACA § 1302.

17. *Id.* § 2718.

18. *See id.* § 2701(a)(1) (stating that insurers may not discriminate on the basis of gender and describing other bases for price differences).

19. *See id.* § 2702(a) (stating that “each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage”).

20. *Id.* § 2714(a).

begins with a centralized place to shop and compare plans: the health insurance exchanges.²¹ The exchanges aim to drive down health insurance prices by allowing consumers to review relevant prices information and comparison shop in a centralized market for health insurance policies.²² Not only can consumers compare prices, but they can learn the total premium revenue spent on nonclinical costs, so that they can judge which policy provides better value.²³

States are invited to set up their own exchanges, potentially adding in their own transparency requirements and promoting their exchanges on their own websites. California has done just that, requiring price transparency measures as a condition of joining the exchange.²⁴

The federally-facilitated exchange (“FFE”) at healthcare.gov discloses information regarding available plans, rate premium information, and summary information about covered benefits and cost sharing, together with other useful information.²⁵ Enforcement of these provisions is

21. *See id.* § 1321; Joshua Phares Ackerman, *The Unintended Federalism Consequences of the Affordable Care Act's Insurance Market Reforms*, 34 PACE L. REV. 273, 273 (2014) (noting that the federal government operates an exchange in any state without one).

22. ACA § 1103; Daniel Schwarcz, *Transparently Opaque: Understanding the Lack of Transparency in Insurance Consumer Protection*, 61 UCLA L. REV. 394, 434 (2014) (noting that transparency provisions of the ACA will allow consumers to comparison shop for plans based on factors such as quality, access, and premiums).

23. ACA § 1103(b). Health plans are required to adopt certain standards for their transactions to keep administration as simple as possible. *See id.* § 1104. The exchange rules require health insurers offering group or individual health insurance coverage to account for their costs on an annual basis, by disclosing the amount spent on reimbursement for clinical services provided, on activities that improve health care, and on “all other non-claim costs.” *Id.* § 2718(a).

24. *See* COVERED CAL., DRAFT HEALTH PLAN CONTRACT 11-12 (2013), available at <http://hbex.coveredca.com/solicitations/QHP/library/Clean%20version%20v4%20QHP%20Model%20Contract.pdf>.

25. *How to Choose Marketplace Insurance*, HEALTHCARE.GOV, <https://www.healthcare.gov/choose-a-plan> (last visited Mar. 17, 2015). The website will also offer information such as the percentage of policies rescinded, the percentage of claims denied, and the number and disposition of appealed and denied claims. Karen Pollitz & Larry Levitt, *Health Insurance Transparency Under the Affordable Care Act*, THE HENRY J. KAISER FAMILY FOUNDATION (Mar.

planned to be a cooperative process involving compliance assistance and cooperation with the states.²⁶

The exchanges' existence, however, does not guarantee success if consumers stay away. To succeed, the ACA requires uptake and enrollment, which in turn requires that consumers know about as well as understand their choices and rights. Many consumers, however, know little about the ACA, and a significant number even believe it has been repealed.²⁷ Individuals can only enroll in the health insurance through the ACA if they know that the opportunity exists. Additional ACA provisions therefore aim to make available the information that consumers need to obtain coverage and make informed decisions.

One of the ACA's means of disseminating information is through direct outreach. The ACA, together with subsequent regulations, provides for a number of individuals who can inform consumers about health insurance options under the ACA, assist with enrollment, and help potential enrollees determine any applicable subsidies. These assistance roles are subject to state or federal oversight through training,

8, 2012), <http://kff.org/health-reform/perspective/health-insurance-transparency-under-the-affordable-care-act>; see ACA § 1311(e).

26. The departments intend to work cooperatively with the states in enforcement; their approach is to work "together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and [to work] with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments." *Affordable Care Act Implementation FAQs-Set 14*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html (last visited Mar. 16, 2015).

27. According to one poll, only fifty-nine percent of people overall knew that the ACA was the law of the land and would be implemented, while the rest were not sure. Phil Galewitz, *10 States Are Critical to Administration's Efforts to Enroll 6 Million in New Health Plans*, KAISER HEALTH NEWS (Mar. 19, 2014) <http://www.kaiserhealthnews.org/stories/2014/March/19/10-states-are-critical-to-administrations-efforts-to-enroll-6-million-in-new-health-plans.aspx>; *Kaiser Health Tracking Poll April 2013*, THE HENRY J. KAISER FAMILY FOUND. (Apr. 30, 2013) [hereinafter *Kaiser Health Tracking Poll April 2013*], <http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-april-2013>.

certification, and approval, and then through ongoing oversight.²⁸

Certified Application Counselors. Exchanges are required to have a certified application counselor program, which is developed by designating organizations to certify counselors or by directly certifying counselors or members of other organizations.²⁹ Certified application counselors are assistance personnel available to give information to consumers and help them enroll in qualified health plans and insurance affordability programs.³⁰ Counselors' duties and obligations—as well as the standards for certifying counselors—are regulated.³¹ To be designated as part of the certified application counselor program, an organization must have experience providing social services to the community, must engage in services that position them to help those they serve with health coverage issues, and have processes in place that screen their staff members and volunteers so as to protect personally identifiable information.³² To be designated, organizations must first apply to the federally-facilitated marketplace.³³ The exchange both oversees counselors and creates a procedure to retract certification if a counselor violates the rules.³⁴

Navigators. In addition, an exchange must create a navigator program.³⁵ Navigators are trained to provide free

28. See 45 C.F.R. § 155.225 (2014); see generally *St. Louis Effort for AIDS v. Huff*, 996 F. Supp. 2d 798 (W.D. Mo. 2014).

29. 45 C.F.R. § 155.225(a)–(b)(2).

30. CTRS. FOR MEDICARE & MEDICAID SERVS., GUIDANCE ON CERTIFIED APPLICATION COUNSELOR PROGRAM FOR THE FEDERALLY-FACILITATED MARKETPLACE INCLUDING STATE PARTNERSHIP MARKETPLACES (2013) [hereinafter CMS, CERTIFIED APPLICATION COUNSELORS], available at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CAC-guidance-7-12-2013.pdf>.

31. 45 C.F.R. § 155.225(d).

32. CMS, CERTIFIED APPLICATION COUNSELORS, *supra* note 30, at 2.

33. *Id.* at 2-3.

34. 45 C.F.R. § 155.225(e).

35. ACA § 1311(d)(4)(k); 45 C.F.R. § 155.210(a) (stating that an exchange “must establish a [federal] Navigator program . . . through which it awards grants to eligible public or private entities or individuals.”).

information about health coverage options to consumers, small businesses, and their employees.³⁶ They are funded through federal and state grants.³⁷ Through these programs and personnel, potential enrollees can learn about their options on the exchanges, find out about any available subsidies, and receive help with the actual application process.

Non-Navigator Personnel. Personnel from states with successful outreach programs emphasize the need for outreach and contact on a personal, one-to-one basis,³⁸ with outreach personnel reaching potential enrollees where they are. This means that navigators and other outreach personnel can most effectively reach potential enrollees not by staying in their offices, but by providing information at sports events, schools, community health centers, grocery stores, and places of leisure.³⁹

Consumer information provisions are therefore a crucial part of the ACA's fundamental goal of increasing the number of Americans with health insurance.

36. *Navigator*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/navigator> (last visited Mar. 17, 2015).

37. DEP'T OF HEALTH & HUMAN SERVS., ASSISTANCE ROLES TO HELP CONSUMERS APPLY & ENROLL IN HEALTH COVERAGE THROUGH THE MARKETPLACE (2013), available at <http://www.cms.gov/ccio/resources/files/downloads/marketplace-ways-to-help.pdf> ("Navigators will have a vital role in helping consumers prepare electronic and paper applications to establish eligibility and enroll in coverage through the Marketplace.").

38. See THE HENRY J. KAISER FAMILY FOUND., PREPARING FOR OUTREACH AND ENROLLMENT UNDER THE AFFORDABLE CARE ACT: LESSONS FROM THE STATES 17 (2013), available at https://kaiserfamilyfoundation.files.wordpress.com/2013/09/092413_kff_outreach_transcript.pdf ("[W]hile marketing campaigns will help educate individuals and raise awareness, enrollment efforts will really be driven at the local level through on-the-ground work. . .").

39. See *id.* at 18-19 (statement of Kathleen Westcoat, HealthCare Access Maryland, noting that the state has developed partnerships with grocery stores, has bought advertising time during popular sports events, and will send personnel to drug stores and other gathering places).

2. Market Reforms and Stronger Consumer Protections

The transparency and consumer information aspects of the ACA permit the ACA's market reforms to function and be enforced. These reforms included the ACA's prohibition on some of the most damaging insurance practices—the barring of individuals with pre-existing conditions⁴⁰ and the elimination of lifetime caps on coverage.⁴¹ Rescission, the practice of cancelling insurance due to an application error after a person files a claim, is also prohibited.⁴²

The ACA also includes new appeal requirements for both internal and external review of claim denials, so that consumers can more effectively challenge an insurance company.⁴³ Additional patient protections include a choice of primary care providers and required coverage of emergency services, pediatric, and obstetrical and gynecological care.⁴⁴

Consumer information is crucial for protection of consumers in financial regulation, particularly insurance,⁴⁵ so that consumers and those who wish to act on their behalf can advocate based on full information.⁴⁶ To disseminate information, the ACA makes grants available to create state offices of health insurance consumer assistance and ombudsman programs.⁴⁷ Even before the ACA, consumer

40. ACA § 2704.

41. *Id.* § 2711.

42. *Id.* § 2712.

43. *Id.* § 2719.

44. *Id.* § 2713(a).

45. *See* Schwarcz, *supra* note 22, at 394.

46. *See id.* (“Broadly construed, transparency involves making relevant information available to consumers as well as others who might act on their behalf, such as academics, journalists, newspapers, consumer organizations, or other market watchdogs.”).

47. The ACA's consumer assistance portion provides:

Health Insurance Consumer Information

(a) In General—The Secretary shall award grants to States to enable such States (or the Exchanges operating in such States) to establish, expand, or provide support for—

(1) offices of health insurance consumer assistance; or

assistance programs run by the states performed a number of different consumer assistance functions, from education to advocacy in the claims process.⁴⁸ To establish or expand these programs under the ACA, the states can apply for grants from the federal government; the offices and ombudsmen then disseminate information regarding available health insurance options, educate consumers regarding their rights, and assist consumers with the complex health claim appeal

(2) health insurance ombudsman programs.

(b) Eligibility

(1) In general—To be eligible to receive a grant, a State shall designate an independent office of health insurance consumer assistance, or an ombudsman, that, directly or in coordination with State health insurance regulators and consumer assistance organizations, receives and responds to inquiries and complaints concerning health insurance coverage with respect to Federal health insurance requirements and under State law.

(2) Criteria—A State that receives a grant under this section shall comply with criteria established by the Secretary for carrying out activities under such grant.

(c) Duties—The office of health insurance consumer assistance or health insurance ombudsman shall—

(1) assist with the filing of complaints and appeals, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer involved and providing information about the external appeal process;

(2) collect, track, and quantify problems and inquiries encountered by consumers;

(3) educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage;

(4) assist consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance; and

(5) resolve problems with obtaining premium tax credits under section 36B of the Internal Revenue Code of 1986.

ACA § 2793(a)–(c).

48. CARRIE TRACY ET AL., MAKING HEALTH REFORM WORK: STATE CONSUMER ASSISTANCE PROGRAMS, CMTY. SERV. SOC'Y 1-7 (2010), *available at* http://www.communityhealthadvocates.org/sites/communityhealthadvocates.org/files/publications/2010/Making_Health_Reform_Work_State_Consumer_Assistance_Programs.pdf. A program in Connecticut, for example, advocated directly for consumers statewide, employing nine staff members and closing 2613 complaints in 2009. *Id.* at 18.

process.⁴⁹ But in addition to disseminating information, consumer assistance programs are meant to serve a “sentinel” role.⁵⁰ That is, the ombudsmen and offices also collect information on the type and number of problems that consumers are experiencing.⁵¹ Indeed, the grants are conditioned upon the collection of such information.⁵² This information would in turn be used to determine the need for enforcement actions at the state and federal levels. Consumer assistance programs can perform this sentinel role most effectively when they remain independent yet maintain avenues for providing feedback to enforcement agencies and policy makers.⁵³

49. *See id.* at 3-7.

50. *Id.* at 7. A consumer assistance program can alert state officials to patterns of non-compliance. *Id.* As an example, in 2008, a Massachusetts citizens assistance program determined from the calls it received that some consumers were not being sent proper recertification documents; the program alerted state officials, who were able to resolve the problem and prevent consumers from losing their insurance. *Id.*; Rachel Grob et al, *The Affordable Care Act’s Plan for Consumer Assistance With Insurance Moves States Forward But Remains a Work in Progress*, 32 HEALTH AFFAIRS 347, 354 (2013) (noting that “[c]onsumer assistance was envisioned under health reform both as a form of patient protection unto itself—universal access to broadly defined assistance—and as a mechanism for promoting robust implementation of new and existing insurance regulations.”).

51. Consumer assistance or ombudsman programs

shall be required to collect and report data to the Secretary on the types of problems and inquiries encountered by consumers. The Secretary shall utilize such data to identify areas where more enforcement action is necessary and shall share such information with State insurance regulators, the Secretary of Labor, and the Secretary of the Treasury for use in the enforcement activities of such agencies.

ACA § 2793(d).

52. *Id.*

53. One study of consumer assistance groups recommended that to be effective, consumer assistance programs should be independent of—but have strong feedback to—regulatory agencies, should serve consumers with all types of coverage, should be based in the communities they serve and have cultural competence and multiple language capacity, should employ trained professional staff, should use online tools, and should have a sustainable funding source. Programs with these characteristics can work with agencies and officials to ensure that enforcement efforts are more effectively directed. TRACY ET AL., *supra* note 48, at 22-23.

The states' department of insurance websites can also be helpful in advising consumers of their rights. Within a few clicks from its home page, for example, the California Department of Insurance website explains the market reforms that are already in effect and those that are soon to be implemented.⁵⁴

Informational transparency thus ensures that consumers have the information they need to learn their rights, while consumer assistance programs collect necessary data for tailored enforcement of consumer protections.

3. Lower Costs and Better Quality in Healthcare Through Information Collection and Dissemination

The ACA aims not simply to lower the cost of health insurance but to lower the cost of healthcare itself. The ACA takes aim at both the high cost of American health care and opacity in health care quality. One means of addressing quality and outcomes is to require the gathering and dissemination of information that will shed light on these issues.⁵⁵ The ACA makes pricing information more available through a provision proposed by the Centers for Medicare and Medicaid Services.⁵⁶ The ACA contains provisions that will allow consumers to compare providers' quality, such as

54. *The Affordable Care Act*, CAL. DEP'T OF INS., <http://www.insurance.ca.gov/01-consumers/110-health/10-basics/aca.cfm> (last visited Mar. 17, 2015) (explaining reforms such as the prohibition on rescission, the guarantee of issue despite pre-existing conditions, and others).

55. ACA § 2717(a)(1) (requiring the development of "reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives.").

56. The requirement can be fulfilled by releasing pricing information after an inquiry. *Fiscal Year 2015 Proposed Policy and Payment Changes for Inpatient Stays in Acute-Care Hospitals and Long-Term Care Hospitals*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Apr. 30, 2014), <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-04-30.html>.

the dissemination of Comparative Effectiveness Research.⁵⁷ This provision requires the collection and dissemination of information about outcomes, risks, and clinical effectiveness of various treatments and services.⁵⁸ The information must be useful and consumer-friendly to enable better decision-making.⁵⁹ This newly-available information will be used to determine and assign quality ratings and to measure and assess quality improvements.⁶⁰ Other measures include administrative simplification⁶¹ and cost-saving changes to Medicare.⁶²

Relationships and exchanges of gifts can influence decision-makers, so the ACA sheds light on these too. The Physician Payment Sunshine provision requires disclosure of gifts worth as little as \$10 to physicians from pharmaceutical companies.⁶³ Practitioners are already anticipating that this provision will result in greater scrutiny and increased enforcement actions.⁶⁴ The ACA also contains reporting and

57. Some commentators believe this provision is an exception to the ACA's overall top-down approach, which regulates at the supply side rather than allowing meaningful consumer participation. Marshall B. Kapp, *Health Reform and the Affordable Care Act: Not Really Trusting the Consumer*, 42 STET. L. REV. 9, 11-18 (2012).

58. Consumers are the intended audience for this information—the information is to be disseminated in a fashion that is “comprehensible and useful . . . in making . . . decisions.” ACA § 6301(d)(8)(A)(i).

59. *Id.*

60. Ledia M. Tabor et al., *Measuring Quality in the Early Years of Health Insurance Exchanges*, 19 AM. J. MANAGED CARE 220 (2013).

61. As much as twenty-four percent of U.S. healthcare spending goes to paperwork and bureaucracy. McDONOUGH, *supra* note 9, at 137. The ACA attempts to lower this number by requiring that HHS create new, uniform standards and operating rules, as well as health insurers' compliance with the rules. *Id.* at 138. Financial penalties are to be levied for non-compliance. *Id.*

62. ACA Title III *passim*. Title III contains approximately \$449 billion in savings, through rate reductions and system improvements. McDONOUGH, *supra* note 9, at 156.

63. *See* ACA § 6002.

64. It seems likely that the increased transparency contemplated by the ACA will result in an increase in enforcement actions under existing fraud and abuse (kickback) laws, and attorneys representing the industry, as well as those advising physicians, teaching hospitals, and other providers, need to be far more attentive to such concerns than they may have been in the past. Paul DeStefano,

transparency provisions with regard to physician ownership of hospitals and nursing homes.⁶⁵ The ACA requires collection of information on race, ethnicity, sex, primary language, and disability status to make this information available to researchers and to work toward reducing disparities.⁶⁶

The ACA also means transparency and movement of information at the physician/patient level, with the requirement that physicians switch to electronic records.⁶⁷ In brief, movement of information occurs at multiple levels and across practically every relationship in healthcare, so that consumers have the information they need to judge price, quality, and even biased decision-making in their healthcare.

4. A New Focus on Prevention

Title IV of the ACA puts in place a national strategy toward disease prevention and early detection. The ACA increases access to preventative services through Medicare by requiring Medicare coverage of wellness and preventive services,⁶⁸ and also through private insurance by requiring coverage of preventative health services and immunizations.⁶⁹ Transparency matters to these provisions

Key Legal Issues and Challenges Facing the Life Sciences Industry, in UNDERSTANDING LEGAL TRENDS IN THE LIFE SCIENCES INDUSTRY 39 (THOMSON REUTERS/ASPATORE 2014).

65. See ACA § 6002.

66. Effective March 23, 2012, the ACA requires the collection and reporting of certain “data on race, ethnicity, sex, primary language, and disability status.” ACA § 4302. The data collection and disaggregation “will help address and reduce disparities faced by communities including lesbian, gay, bisexual and transgender (LGBT) Americans.” *The Second Anniversary of Health Care Reform is Good News, Will There be a Third?*, CTR. FOR MEDICARE ADVOCACY, <http://www.medicareadvocacy.org/the-second-anniversary-of-health-care-reform-is-good-news-will-there-be-a-third> (last visited Mar. 17, 2015). This information is to be made publicly available and is to be provided to various offices and institutions. *Id.* Within four years after the ACA’s enactment, the Secretary is to report to Congress and recommend improved means for identifying disparities. ACA § 1946(b)(2).

67. ACA § 1104.

68. ACA § 4103-05.

69. *Id.* § 2713.

too, with requirements such as the inclusion of calorie counts on restaurant menus.⁷⁰

Thus, the ACA is steeped in informational transparency provisions, particularly with regard to consumer access to information about benefits, rights, and health insurance company practices. The ACA's basis in cooperative federalism, however, means that the states are free to reject some of the most significant informational transparency provisions—and many states have chosen to do exactly that.

II. OBSTRUCTIVE FEDERALISM AND THE WAR ON INFORMATIONAL TRANSPARENCY

The ACA's consumer information transparency provisions are vulnerable to state resistance and obstruction because the consumer information provisions are designed to include a significant role for state governments. As a whole, the ACA sets out a variety of different combinations of state and federal roles addressing health insurance coverage, consumer protections, cost of care, and other issues. Some provisions call for the federal government to act alone, others leave actions entirely to the states, and some invite state participation but retain a federal fallback if the states do not act. The latter, a combined federal/state approach known as "cooperative federalism," allows the states to tailor programs according to their citizens' particular needs and desires.⁷¹ In the ACA's case, however, cooperative federalism also allows anti-ACA states to reject completely some portions of the ACA, particularly those that would be most helpful to consumers: those addressing communication with consumers on the matter of coverage availability and options, rate review, and consumer rights.

70. Section 4205 requires calorie labeling on chain restaurant menus, and section 4101 provides \$50 million in grants for school-based clinics serving medically underserved families and children, for fiscal years 2010 through 2013.

71. See, e.g., Elizabeth Weeks Leonard, *State Constitutionalism and the Right to Health Care*, 12 U. PA. J. CONST. L. 1325, 1338 (2010) (discussing cooperative federalism and programs in which the state spent monies but also received monies from the federal government). For a further discussion, see Susan Rose-Ackerman, *Cooperative Federalism and Co-optation*, 92 YALE L.J. 1344 (1983) (discussing approaches to cooperative federalism).

A. Cooperative Federalism

The ACA's basis in cooperative federalism arises out of constitutional concerns, practical considerations, and political necessity. Traditionally, the states dealt with insurance regulation, leaving the federal government with less experience in such matters.⁷² Other reasons make state participation an appealing option—state governments are closer to citizens' concerns. Because the states are smaller units of government, citizens are more likely to be able to have their voices heard and recognized; the state government can therefore be more responsive to its citizens than the federal government can be.⁷³ With regard to certain programs, the states are able to carry out the federal program's goals effectively and connect more easily with citizens. With regard to health care, proponents of a greater state role have stressed local variation and the expertise of state health personnel on the ground.⁷⁴ And, with regard to the states, numerous aspects of state constitutions provide

72. Richard A. Epstein & David A. Hyman, *Fixing Obamacare: The Virtues of Choice, Competition, and Deregulation*, 68 N.Y.U. ANN. SURV. AM. L. 493, 511 (2013); Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L.J. 534, 565-66 (2011) [hereinafter Gluck, *Intrastatutory Federalism*] (noting that "there are many other reasons that the federal government uses state implementers . . . the value of policy experimentation, state autonomy, the inability of uniform solutions to fit diverse localities, citizens' greater ability to participate in the local political process, the comparative strengths of the states in certain areas of the law, and the fact that pockets of state control serve as important checks on national authority."). The states' role in insurance matters has been less sovereign in recent decades, however, with the federal government's encroachment on the states' authority through programs such as Medicaid, the State Children's Health Insurance Program (SCHIP) and others that function through both state and federal participation. Kyle Thomson, *State-Run Insurance Exchanges in Federal Healthcare Reform: A Case Study in Dysfunctional Federalism*, 38 AM. J.L. & MED. 548, 549 (2012) (citing PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982)).

73. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2578 (2012) (noting that "the facets of governing that touch on citizens' daily lives are normally administered by smaller governments closer to the governed").

74. Abbe R. Gluck, *Federalism From Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists' Gamble*, 81 FORDHAM L. REV. 1749, 1751-52 (2013).

the means to ensure that the states remain responsive to their citizens.⁷⁵

Politics also drove the ACA's inclusion of state preferences. As a practical matter, the ACA was more palatable politically due to its status as a state/federal program rather than a purely federal one.⁷⁶ The Republicans preferred from the outset a federally-financed but state-administered approach, as opposed to a purely federal one.⁷⁷ Indeed, without this structure, the ACA may not have passed at all.⁷⁸ With the ACA, the Republicans prevailed and received their preferred structure.⁷⁹

Cooperative federalism presents a delicate balance, however, because the federal government's power to control the actions of state governments is limited. As the Supreme Court reiterated in *NFIB v. Sebelius*,⁸⁰ the federal government cannot take control of state apparatuses to carry

75. James A. Gardner, *Devolution and the Paradox of Democratic Unresponsiveness*, 40 S. TEX. L. R. 759, 765-68 (1999) (describing features of state governments that make them more responsive to their citizens, such as opportunity to elect lower-level officials, provisions for popular recall, term limits, limits in taking on debt, and others).

76. See, e.g., MCDONOUGH, *supra* note 9, at 128.

77. *Id.*

78. Gluck, *Intrastatutory Federalism*, *supra* note 72, at 578 ("Giving the states the leadership role was the concession ultimately required to close the deal."). In the end, the cooperative federalism model was the only one that could pass, due to the procedural posture of the bills after the loss of Democrats' sixty-vote majority in the senate following the Massachusetts special election. MCDONOUGH, *supra* note 9, at 128. The House reform plan envisioned a single, federally-run exchange, but in the reconciliation process, the Senate version prevailed. *Id.* But, after Democrats lost their sixty-vote majority in the Senate following the Massachusetts special election to replace the deceased Senator Kennedy, health reform could only be passed via the reconciliation process, which required only fifty-one votes for passage. *Id.* at 94. Under reconciliation, the only changes that can be made are those that have a direct and substantial impact on the budget. *Id.* at 97. The Senate parliamentarian had ruled that no changes could be made to the Senate bill's exchange structure, because those would not affect the budget. *Id.* at 128. Therefore, the Senate version of the exchanges—which invited state participation—stayed in the final bill. *Id.*

79. MCDONOUGH, *supra* note 9, at 128.

80. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2607 (2012).

out its goals⁸¹—the federal government possesses only enumerated powers, not a “general authority to perform all the conceivable functions of government.”⁸² The constitutionality of any particular federal/state program turns on the issue of choice—that is, does the state have a “genuine choice” available to not follow the federal request?⁸³

Using this analysis, the ACA’s offering of grants with conditions attached did not violate the anti-commandeering principle,⁸⁴ but the mandatory Medicaid expansion did.⁸⁵ In the case of the Medicaid expansion, the Court ruled that there was no such “genuine choice,” because the ACA threatened to take away all of a recalcitrant state’s Medicaid payments, which generally represent 20% of a state’s total budget.⁸⁶ In making this determination, the Court potentially

81. “Congress may not simply ‘conscript state [agencies] into the national bureaucratic army.’” *Id.* at 2606-07 (alteration in original) (quoting *Fed. Energy Regulatory Comm’n v. Mississippi*, 456 U.S. 742, 775 (1982) (O’Connor, J., concurring in the judgment in part and dissenting in part)).

82. *Id.* at 2577.

83. *See id.* at 2607-08.

84. *Id.* at 2607 (“Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use.”).

85. The Court illustrated its reasoning with the example of Congress’s tying of highway funds to the states’ minimum drinking age. When Congress threatened five percent of the states’ federal highway funds if they did not raise their minimum drinking age to twenty-one years of age, the provision was permissible because of the scale of the inducement: five percent of highway funds represented less than half a percent of South Dakota’s budget at the time South Dakota challenged the drinking age requirement. *Id.* at 2604. This, the Court explained, was a “relatively mild encouragement.” *Id.* (quoting *South Dakota v. Dole*, 483 U.S. 203, 211 (1987))

86. *Id.* Chief Justice Roberts’s opinion explained the ACA could permissibly require the states to comply with the ACA’s conditions so as to qualify for the funding associated with the Medicaid expansion. *Id.* at 2607. The impermissible piece, however, was Congress’s requirement that the states either participate in the “new program” of Medicaid expansion or lose their Medicaid funds completely, including funds for Medicaid as it existed before the ACA. *Id.* The opinion describes the expanded Medicaid as distinct from Medicaid pre-ACA. *See id.* Threatening states with the loss of their existing Medicaid funding streams—funds constituting, on average, more than twenty percent of a state’s annual budget—“is much more than ‘relatively mild encouragement’—it is a gun to the

altered the anti-commandeering doctrine, with significant implications for numerous programs.⁸⁷

The ACA contains a variety of different combinations of federal/state roles; some provisions are purely federal, effective without state participation, while others envision the states and the federal government working in tandem.⁸⁸ With regard to the exchanges, for example, state participation is invited, with a federal backup.⁸⁹ The states are meant to set up and operate exchanges, which are entities that “facilitate[] the purchase” of health insurance.⁹⁰ The ACA sets out a mechanism for states to put in place their own exchanges,⁹¹ but if a state does not set up an exchange, the Secretary of Health and Human Services will establish and operate an exchange in that state.⁹² This combination of state and federal oversight represents a departure from the states’ traditional role as the exclusive authority over insurance, healthcare, and public health matters within their borders.⁹³

In other areas, the ACA sets a mandatory federal floor for the states, preempting state law and imposing strict penalties. The market reforms, for example, speak directly to insurance companies—a state opt-in is not required for

head.” *Id.* at 2604. Because the Act offered the states no “genuine choice” or “real option” other than to implement the ACA’s Medicaid expansion, reasoned the Chief Justice, it “require[d] the States to govern according to Congress’ instructions,” violating the structural principles of federalism. *Id.* at 2602, 2605, 2607.

87. See, e.g., Bradley W. Joondeph, *The Health Care Cases and the New Meaning of Commandeering*, 91 N.C. L. REV. 811, 832-36 (2013).

88. Gluck, *Intrastatutory Federalism*, *supra* note 72, at 577 (“Some provisions in the statute, like those concerning the insurance exchanges, are expressly intended to be ‘state led’; others, like the Medicare provisions, are unquestionably federally focused; still others, such as the Medicaid provisions and the insurance regulation provisions, lie somewhere in between, with a role clearly foreseen for state and federal regulators acting concurrently.”).

89. ACA § 1311(b)(1)(A).

90. *Id.*

91. *Id.*

92. *Id.* § 1321(c). To operate its exchanges in non-state-exchange states, HHS contracts with not-for-profit entities. *Id.*; 45 C.F.R. § 155 (2014).

93. Thomson, *supra* note 72, at 549 (citing STARR, *supra* note 72)).

implementation.⁹⁴ While the states can enact laws that are more consumer-friendly than those in the ACA, provisions such as the prohibition on barring consumers with pre-existing conditions apply, regardless of a particular state's desires.⁹⁵ With regard to providing a summary of benefits and coverage, for example, the ACA sets a compliance standard, preempts all state laws that require less disclosure than the federal standard, and imposes a strict penalty of \$1000 per day, per violation, per insured person.⁹⁶

Cooperative federalism's dual state and federal implementation is not without its pitfalls—the federal government's delegation of authority to the states poses a risk of “uncooperative administration.”⁹⁷ While the ACA is not the first program to call for state and federal cooperation, it was passed in a highly partisan atmosphere in which ACA opposition has become almost a badge of honor among certain groups.⁹⁸ The ACA passed without a single Republican vote,⁹⁹

94. *E.g.*, ACA §§ 2704-06.

95. *See id.* § 2701(a)(1) (stating that insurers may not discriminate on the basis of gender and describing other bases for price differences).

96. *Id.* § 2715.

97. Some have predicted that as designed, the ACA's approach to cooperative federalism is destined to fail, due to possible continued constitutional challenges and political debate, particularly with regard to the exchanges. *See* Thomson, *supra* note 72, at 550. Thomson argues that because very little variation in the state exchanges is contemplated, the exchange program does not harness the potential benefits of cooperative federalism, and the exchanges would be better suited to be an exclusively federal construct. *Id.*; *see also* Gluck, *Intrastatutory Federalism*, *supra* note 72, at 605 (noting that “[t]he ability of states to opt out of administering federal programs or to administer them disloyally illustrates one kind of ‘autonomy’ that states still retain, and is something that significantly distinguishes them from federal agencies.”).

98. EZEKIEL J. EMANUEL, *REINVENTING AMERICAN HEALTH CARE* 280 (2014) (describing the partisan atmosphere as one in which “conservatives—politicians and the conservative media—were literally rooting for the ACA to crash and took every glitch as an opportunity to declare it a total failure.”).

99. On December 24, 2009, the Patient Protection and Affordable Care Act passed the Senate with sixty votes in favor and thirty-nine opposed; the positive votes were all from Democrats. *U.S. Senate Roll Call Votes 111th Congress-1st Session*, U.S. SENATE, http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=1&vote=00396 (last visited Mar. 17, 2015). The House voted on March 21, 2010, with 220 in favor and 211 against, with the votes in favor still coming only from Democrats. *Final Vote Results for*

and it remains a highly controversial law, dividing public opinion. According to national polls, at the end of April 2014, after the first open enrollment period closed, 46% of people had a negative opinion of the ACA, while 38% of people had a positive opinion of the law.¹⁰⁰ Public sentiment against the ACA was and remains particularly strong in southern, Republican-led states.¹⁰¹

Roll Call 167, U.S. HOUSE OF REPRESENTATIVES, <http://clerk.house.gov/evs/2010/roll167.xml> (last visited Mar. 17, 2015). In the reconciliation process, the Senate voted fifty-six in favor and forty-three against to approve the bill and its amendments on March 25, 2010. *U.S. Senate Roll Call Votes 111th Congress-2nd Session*, U.S. SENATE, http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=2&vote=00105 (last visited Mar. 17, 2015).

100. *Public Opinion on the ACA at the End of the First Open Enrollment Period*, THE HENRY J. KAISER FAMILY FOUND., <http://kff.org/slideshow/public-opinion-on-the-aca-at-the-end-of-the-first-open-enrollment-period> (last visited Mar. 17, 2015).

101. In a New York Times/Kaiser poll of individuals in Arkansas, Kentucky, Louisiana, and North Carolina, the majority of individuals disapproved of the ACA. In Arkansas, 62% disapproved; in Kentucky, 55% disapproved; in Louisiana, 59% disapproved, and in North Carolina, 54% disapproved. Sabrina Tavernise & Allison Kopicki, *Southerners Don't Like Obamacare. They Also Don't Want to Repeal It*, N.Y. TIMES (Apr. 23, 2014), http://www.nytimes.com/2014/04/24/health/health-law-repeal-has-little-support-poll-finds.html?_r=0. In Texas, 54% disapproved and 33% approved. *Texans on the Affordable Care Act*, TEX. POLITICS PROJECT (Oct. 2013), http://texaspolitics.utexas.edu/archive/html/poll/features/201310_ACA/slide1.html (last visited Mar. 17, 2015). Opinion on the ACA is divided along party lines. For example, 11% of Texas Democrats oppose the law and 73% favor it, while 85% of Texas Republicans opposing the law and 4% favor it. *Texans on the Affordable Care Act*, TEX. POLITICS PROJECT (Oct. 2013), http://texaspolitics.utexas.edu/archive/html/poll/features/201310_ACA/slide2.html (last visited Mar. 17, 2015); see also Lizette Alvarez & Robert Pear, *Florida Among States Undercutting Health Care Enrollment*, N.Y. TIMES (Sept. 17, 2013), <http://www.nytimes.com/2013/09/18/us/florida-among-states-undercutting-health-care-enrollment.html?pagewanted=all> (reporting on the opposition from Florida, Missouri, and Ohio Republicans). Nationally, opinion polls show a partisan divide in opinions on the ACA, with 68% of Democrats approving of the ACA and 17% disapproving in April 2014, while 76% of Republicans disapproved and 11% approved. *Health Tracking Poll Exploring the Public's Views on the Affordable Care Act*, THE HENRY J. KAISER FAMILY FOUND., <http://kff.org/interactive/health-tracking-poll-exploring-the-publics-views-on-the-affordable-care-act-aca> (last visited Mar. 17, 2015) (follow "PARTY ID" link; then follow "Democrat" or "Republican" link); see also KYLE A. DROPP ET AL., CTR. FOR EFFECTIVE PUB. MGMT., *THE AFFORDABLE CARE ACT: AN EXPERIMENT IN FEDERALISM?* 2 (2013), available at <http://www.brookings.edu/~media/research/>

Acceptance or rejection of the ACA tends to follow party lines—the twelve states with governors and both chambers of their legislatures controlled by Democrats have all opted to operate their own exchanges.¹⁰² Of the twenty-seven states giving control of exchanges to the federal government, twenty-four have Republican governors; twenty-two of the twenty-seven have Republican-majority state Senates.¹⁰³ Republican leaders are under intense pressure to reject the ACA.¹⁰⁴ Some posit that those states that have declined to implement the exchanges have leaders who actively want the ACA to fail.¹⁰⁵ In that regard, the ACA faces challenges to implementation that other programs based on cooperative federalism have not.¹⁰⁶ Perhaps predictably, in the implementation of certain ACA provisions involving informational transparency for consumers, the intended cooperative federalism has splintered into obstructive federalism that undermines the ACA's goals with regard to consumers.

B. *Obstructive Federalism and the ACA's Transparency Provisions*

While the Medicaid non-expansion is the best known area of anti-ACA states' resistance, certain states' rejection of the ACA's outreach and informational transparency provisions is damaging too. And, while opposition to the

files/papers/2013/10/affordable%20care%20act%20experiment%20in%20federalism/droppjackman%20and%20jackmanaca%20experment%20in%20federalism102213.pdf (noting the “partisan opposition to health care reform at the state level”).

102. DROPP ET AL., *supra* note 101, at 1, 4-6.

103. *Id.* at 6.

104. See Sara Rosenbaum, *Can This Marriage Be Saved? Federalism and the Future of U.S. Health Policy Under the Affordable Care Act*, 15 MINN. J.L. SCI. & TECH. 167, 170-71 (2014) (describing the polemics against any move towards cooperative federalism).

105. DROPP ET AL., *supra* note 101, at 6.

106. NAT'L ACAD. OF SOC. INS., REFLECTIONS ON IMPLEMENTING MEDICARE (M.G. Gluck & V. Reno eds., 2001), available at http://www.nasi.org/usr_doc/med_report_reflections.pdf; Jonathan Oberlander, *Obamacare Faces Hurdles that Medicare Did Not*, N.Y. TIMES (May 29, 2013), <http://www.nytimes.com/roomfordebate/2013/05/29/is-obamacare-too-complicated-to-succeed/obamacare-faces-hurdles-that-medicare-did-not>.

Medicaid expansion and other provisions is softening in many states due to pragmatic concerns, the anti-information stance shows little sign of retreat.

1. Obstructive Federalism and the Softening
Opposition to Medicaid's Expansion

The anti-ACA states' refusal to expand Medicaid is their most heavily criticized act of opposition. But the same states that loudly reject the expansion are at the same time working quietly to find pragmatic solutions that may eventually expand Medicaid almost as the ACA's drafters originally designed.

The ACA was drafted with the Medicaid expansion fulfilling an important place in the patchwork of health insurance coverage opportunities that would, together, bring a new thirty-two million people under the health insurance umbrella.¹⁰⁷ Medicaid previously insured mainly individuals in defined categories, such as children, parents with dependent children, the disabled, and the elderly.¹⁰⁸ The expansion would have made individuals eligible for Medicaid provided they earn no more than 138% of the poverty line.¹⁰⁹ Those with higher incomes are eligible for federal tax subsidies of their premiums through federal law and with no state participation necessary.¹¹⁰ With the mandatory Medicaid expansion deemed unconstitutional under *Sebelius*, twenty-four states (as of March 2014) have decided not to expand Medicaid in their states.¹¹¹

Despite the strident political opposition to expanding Medicaid, there are signs of softening opposition in some states. Even the state of Texas, whose governor once

107. See Hall, *supra* note 9 and accompanying text.

108. *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, THE HENRY J. KAISER FAMILY FOUND. (Apr. 2, 2014), <http://kff.org/report-section/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid>.

109. *Id.*

110. *Id.*

111. *Id.*

compared the Medicaid expansion to the Titanic,¹¹² seems to show some signs that pragmatic fiscal concerns might eventually result in a negotiated settlement over the expansion of Medicaid.¹¹³ A more pragmatic approach is palatable to many constituencies, such as charitable groups¹¹⁴ and healthcare providers.¹¹⁵ When individuals do not have health insurance, they pay “only about 35-38% of the total medical costs they incur.”¹¹⁶ The remainder of the cost is paid by charitable organizations, the insured, and the government, while the providers themselves end up paying the balance.¹¹⁷ Hospitals are bearing the brunt of the failure to expand Medicaid, as they continue to see low-income patients; but the low-income patients lack health insurance coverage or Medicaid to pay their bills.¹¹⁸ Hospitals are therefore likely to become advocates for the expansion of

112. Kathryn Smith, *Rick Perry: Medicaid Is Like Adding People to Titanic*, POLITICO (July 9, 2012, 12:22 PM), <http://www.politico.com/news/stories/0712/78239.html>.

113. Texas officials continue to push for a federal block grant to expand Medicaid as the state sees fit—to date, this proposal has not been accepted. *See, e.g.*, Becca Aaronson, *Zerwas Proposes Alternative to Medicaid Expansion*, TEX. TRIBUNE (Apr. 16, 2013), <http://www.texastribune.org/2013/04/16/zerwas-proposes-alternative-medicaid-expansion>.

114. *See generally* STACEY CHAZIN & VERONICA GUERRA, CTR. FOR HEALTH CARE STRATEGIES, INC., IMPACT OF THE AFFORDABLE CARE ACT ON CHARITY CARE PROGRAMS (2013), available at http://www.chcs.org/media/Charity_Care_Brief_090413_FINAL.pdf.

115. Pressure continues to build on the governor, however, given the anticipated reductions in funding for hospitals that treat the uninsured. *See* Becca Aaronson, *Without Medicaid Expansion, Hospitals Seek Long-Term Solution*, TEX. TRIBUNE (Feb. 14, 2014), <http://www.texastribune.org/2014/02/14/without-medicaid-expansion-hospitals-seek-long-ter>.

116. Edward A. Morse, *Lifting the Fog: Navigating Penalties in the Affordable Care Act*, 46 CREIGHTON L. REV. 207, 216 (2013) (citing Brief Amici Curiae of Economic Scholars in Support of Defendants-Appellees at 13, *Liberty Univ., Inc. v. Geithner*, 671 F.3d 391 (4th Cir. 2011) (No. 10-2347)).

117. *See* Brief Amici Curiae of Economic Scholars in Support of Defendant-Appellees, *supra* note 116, at 13-14.

118. *See* Jonathan Oberlander, *The Future of Obamacare*, 367 NEW ENG. J. MED. 2165-67 (2012); *State's Inaction on Coverage for the Working Poor Has Consequences for Uninsured, Taxpayers, Hospitals*, TEX. HOSP. ASS'N., <https://www.tha.org/HealthCareProviders/Issues/HealthCareCoverage/StatesInactiononCoF0933/index.asp> (last visited Mar. 17, 2015).

Medicaid.¹¹⁹ Given these considerations, some opposition states have found more palatable a plan that supplements private health insurance but does not directly expand the Medicaid program.¹²⁰ Because the states stand to gain considerable federal funds from the Medicaid expansion, expanding Medicaid in some fashion would make sense.¹²¹

Some predict that after the 2016 election, states that now reject the Medicaid expansion will opt to expand Medicaid, in two waves.¹²² The last wave will include states such as Texas, which may take until after the 2020 election to expand, just as the last state to implement Medicaid did so seventeen years after the program's enactment.¹²³ Thus, even as governors and legislators in anti-ACA states declare their opposition to the Medicaid expansion, their stance is shifting. In addition, state health officials are moving forward with other reforms on the ground.¹²⁴ The rejection of Medicaid's expansion is thus yielding to political and financial costs that do not apply as directly to the consumer information transparency provisions.

2. Obstructive Federalism's Hostility to Consumer Information Transparency

Some anti-ACA states remain steadfastly against many of the informational transparency provisions that invite state participation and that would help consumers obtain their

119. See Oberlander, *The Future of Obamacare*, *supra* note 118, at 2166.

120. Indiana Governor Mike Pence, for example, urged repeal of the ACA yet offered a solution to the non-expansion of Medicaid in his state. Ken Thomas, *Pence Promotes Alternative Healthcare Proposal*, AP NEWS (May 19, 2014), <http://bigstory.ap.org/article/pence-promotes-health-care-proposal-dc>. His plan would enlarge an existing Indiana program, which provides health savings accounts to those with incomes of up to 138% of the poverty line. *Id.* The governor believes that this program allows people to make their own choices with regard to health insurance. *Id.*

121. EMANUEL, *supra* note 98, at 295.

122. *Id.*

123. *Id.* at 295-97.

124. Gluck, *Intrastatutory Federalism*, *supra* note 72, at 591 (noting that "at the same time that governors (and state attorneys general) in a number of states that are publicly opposing the new reforms, their state bureaucracies are moving ahead (with the governors' approval) to implement them.").

ACA benefits and rights. While certain informational transparency provisions take effect without regard to the states' actions or opinions, others call for state participation. Significantly, the provisions that concern communication with consumers on the ground regarding their options and their rights are also those that give states the greatest flexibility in their implementation.

Unlike the non-expansion of Medicaid, the undermining of informational transparency operates quietly, with little controversy. While the non-expansion of Medicaid has awoken a groundswell of stakeholder opposition, the undermining of informational transparency provisions has provoked little push to reverse course.

a. *Refusing State Exchanges.* States that decline to implement their own exchanges are declining not just a purchasing place for consumers, but the opportunity to promote health insurance to the uninsured, to increase enrollment, and to connect citizens to other programs.

The ACA allows states to set up their own health insurance exchanges but provides a federal exchange for states that do not implement their own.¹²⁵ The ACA permits and encourages variety in state implementation of the exchanges.¹²⁶ Twenty-seven states have declined to set up exchanges to sell and promote health insurance purchases.¹²⁷ Citizens of these states can still shop for federally-subsidized health insurance and compare plan costs and other features by using the federal exchanges.¹²⁸ Given this federal fallback,

125. See ACA § 1321(c).

126. The ACA mentions "state flexibility" numerous times, see *id.* §§ 1321, 1331, 1412, and also has a waiver provision allowing states to apply for permission to use their own programs to accomplish the ACA's goal. See *id.* § 1332.

127. *State Health Insurance Marketplace Types, 2015*, THE HENRY J. KAISER FAMILY FOUND., <http://kff.org/health-reform/state-indicator/health-insurance-exchanges> (last visited Mar. 17, 2015).

128. TIMOTHY STOLTZFUS JOST, HEALTH INSURANCE EXCHANGES & THE AFFORDABLE CARE ACT: KEY POLICY ISSUES 31 (2010), available at <http://www.thalassemia.org/updates/pdf/HealthInsuranceExchanges.pdf> (noting that the ACA "establishes federal fallback authority to create a federal exchange as well as a multistate insurance program.").

does state non-participation matter?¹²⁹ The early signs suggest that it does.

Citizens of non-exchange states can still shop for the ACA's federally-subsidized insurance, but insurance availability is not the state exchanges' only intended function—state exchanges serve a connective and informational function too. The ACA requires that when states set up their own exchanges, the exchange must have “streamline[d] and simplif[ied] application processes” for the state's state and federal healthcare programs.¹³⁰ Thus, when fully integrated with a state's other public programs, a state exchange can funnel participants to an array of other programs.¹³¹ At its most ambitious and integrated, a state exchange can disseminate information through vertical and horizontal integration of federal and state benefits.¹³² An exchange can thereby increase uptake in a variety of programs by serving as a full service access point.¹³³ Through approaches such as these, the exchanges can limit the “bureaucratic disentanglement” that limits participation in

129. See Gluck, *Intrastatutory Federalism*, *supra* note 72, at 565.

130. EAST BAY CMTY. LAW CTR., THE OBAMACARE OPPORTUNITY: IMPLEMENTING THE AFFORDABLE CARE ACT TO IMPROVE HEALTH, REDUCE HARDSHIP, AND GROW THE ECONOMY FOR ALL CALIFORNIANS 10 (2013) [hereinafter EAST BAY, OBAMACARE OPPORTUNITY], available at https://ebclc.org/documents/Obamacare_Opportunity.2013.08.pdf.

131. JOST, *supra* note 128, at 30 (“The exchanges play important roles as advocates of insurance affordability, as administrators of cost-sharing reduction subsidies, and as gateways to other public programs.”).

132. EAST BAY, OBAMACARE OPPORTUNITY, *supra* note 130.

133. See *id.* at 4. One non-exchange state—Pennsylvania—provides an example of such access. Pennsylvania provides access to thirteen benefit programs using a single application. *Id.* at 15 n.81 (noting that “COMPASS integrates the applications of the following programs: Medicaid, Medicare, CHIP, case assistance (TANF, diversion program, state blind program, refugee cash assistance program), LIHEAP, SNAP, home and community-based services, long term care, and school meals”). ACA exchanges could act as a similar one-stop place to enroll in numerous programs.

benefits.¹³⁴ The state exchanges thus present an opportunity to improve access to benefits for individuals and families.¹³⁵

Early statistics show some indications that generally, states with their own exchanges have achieved greater enrollment of uninsured individuals than have states that rely on the federal exchanges.¹³⁶ Enrollment is higher in those states with their own exchanges, and those states spent larger amounts of money on promotion of health insurance to potential insureds.¹³⁷ The states with federally-facilitated exchanges did, however, enjoy a surge in enrollment toward the end of the enrollment period.¹³⁸ Despite the surge, enrollment of uninsured individuals still lags in states without exchanges.¹³⁹ The reasons for this lag are difficult to

134. *Id.* at 9.

The negative effect of quality control reports is an example of “bureaucratic disentanglement”: largely obscure bureaucratic actions and inactions that effectively reduce welfare benefits by making participation in the program more difficult. The sources of such reductions, political in nature, are often difficult to pinpoint. They usually appear as administrative decisions, such as budgetary allocations or cut backs, but directly affect the receipt of benefits. Bureaucratic disentanglement thus keeps welfare agencies from meeting their constituents’ needs.

Maria Fazzolari, *The Brown v. Guiliani Injunction: Combating Bureaucratic Disentanglement*, 23 FORDHAM URB. L.J. 413, 421-22 (1996).

135. EAST BAY, OBAMACARE OPPORTUNITY, *supra* note 130, at 10.

136. DANIEL E. POLSKY ET AL., ROBERT WOOD JOHNSON FOUND., DECIPHERING THE DATA: FINAL ENROLLMENT RATES SHOW FEDERALLY RUN MARKETPLACES MAKE UP LOST GROUND AT END OF OPEN ENROLLMENT 2-3 (2014) [hereinafter POLSKY ET AL., FINAL ENROLLMENT], *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf411792; DANIEL E. POLSKY ET AL., ROBERT WOOD JOHNSON FOUND., DECIPHERING THE DATA: STATE-BASED MARKETPLACES SPENT HEAVILY TO HELP ENROLL CONSUMERS 3 (2014) [hereinafter POLSKY ET AL., STATE-BASED MARKETPLACES], *available at* http://dihealtheconomist.com/media/state-based_marketplaces_spent_heavily_to_enroll_consumers.pdf (“Enrollment data to date suggests wide variations in how successful states were in enrolling their eligible populations in private plans with [state-based exchange states], in general, having more success than [state with federally-facilitated marketplaces].”).

137. POLSKY ET AL., FINAL ENROLLMENT, *supra* note 136, at 2-3.

138. *Id.* at 1, 5 (noting that while enrollment in states with state-run exchanges still outpaced those with federal exchanges, “the federally facilitated marketplaces and some of the troubled state-based ones made up some ground in the last four to six weeks of the open enrollment period.”).

139. *Id.* at 2.

pinpoint and are likely multiple. One possible reason, however, is that citizens are more willing to look to state resources for help with insurance.¹⁴⁰

Another is the federally-facilitated exchange states' lack of support for outreach, as discussed below. Many argue that the key to a successful exchange is marketing and promotion.¹⁴¹ In states relying exclusively on the federal exchange, there is often a lack of the most basic information about the availability of health insurance on the federal exchange.¹⁴² And, as described below, these states also tend to be the same ones that have rejected navigators, consumer assistance centers, and other forms of information dissemination set out in the ACA.

Thus, by abdicating responsibility for the exchanges to the federal government, the states are missing an opportunity to promote their own exchanges and improve enrollment.

140. *Id.* at 5 (speculating that the states' traditional role in insurance may have contributed to their faster start in enrollment).

141. "One of the key takeaways regarding enrollment is that advertising and strong political support are critical to successful enrollment." Zarak Khan, Behavioral Economics and the Affordable Care Act: What States Should Know As They Design Health Insurance Exchanges 6 (Apr. 17, 2013) (unpublished Master's thesis, Sanford School of Public Policy) (on file with the Duke University Library system); see POLSKY ET AL., FINAL ENROLLMENT, *supra* note 136, at 5 (noting that "structural decisions may ultimately not be as important in enrollment success as more process-oriented ones, such as marketing and outreach to eligible populations, and consumer assistance in navigating the new marketplaces.").

142. In Oklahoma, for example, citizens who turn to their state insurance department's website for help with health insurance find no information about the federal exchange. See Warren Vieth, *State Makes Little Effort to Promote Health Exchange*, OKLAHOMA WATCH (Aug. 17, 2013), <http://oklahomawatch.org/2013/08/17/state-offers-little-help-with-navigating-health-exchange> (noting that, six weeks before the ACA's 2013-14 open enrollment was to begin, the state department of health website had no information about the possibility of signing up for health insurance on the federal exchange and the department of insurance discussed the state's opposition to the ACA without any information on signing up for health insurance).

b. *Silencing Enrollment Outreach.* Lack of information remains a major barrier to enrollment in public health care programs.¹⁴³ The purchase of health insurance is a complex one, requiring knowledge of where and how to purchase insurance, the features of various plans, and the available subsidies—outreach and marketing is therefore crucial. Nevertheless, some states impose restrictions on navigators and burden or reject other avenues of communication about the ACA. Former Health and Human Services Secretary Kathleen Sebelius asserted that Republicans are purposely keeping information from would-be ACA enrollees.¹⁴⁴ Purposeful or not, the result of these burdens and information gaps is a form of soft bureaucratic disenfranchisement,¹⁴⁵ by which individuals are unable to claim the benefits to which they are entitled, due to bureaucratic actions or inactions. Specific actions against informational transparency for enrollees include the burdening of navigators and the refusal of funds for consumer assistance centers.

i. *Burdening Navigators.* As explained above, the ACA recognizes potential enrollees' need for information and provides that insurance navigators will assist in explaining the law and helping individuals enroll in new insurance. Where a state does not develop its own exchange, the federal exchange acts as a fallback, together with its own navigator

143. EAST BAY, OBAMACARE OPPORTUNITY, *supra* note 130, at 8 (“Some people who are eligible do not apply for benefits because they do not know about the program or do not realize they qualify for it.”); Jennifer Stuber & Elizabeth Bradley, *Barriers to Medicaid Enrollment: Who Is at Risk?*, 95 AM. J. PUB. HEALTH 292 (2005) (noting that about twenty percent of poor children are not enrolled in Medicaid and analyzing risk factors for failed uptake, such as health status, race, level of education, lack of access to transportation, and complexity of enrollment procedures).

144. According to Sebelius, “[t]he single largest challenge is to get information to individuals who may be eligible for benefits but really don’t know anything about the market.” Daniel Chang, *Sebelius Spreads the Word on Healthcare Reform in Miami-Dade*, MIAMI HERALD (Sept. 17, 2013), <http://www.miamiherald.com/news/local/community/miami-dade/article1955172.html> (noting that Sebelius thought Florida Republicans had been “keeping information from people” and stating that the greatest challenge was getting information to those people who might want to enroll).

145. See Fazzolari, *supra* note 134, at 421-22.

program. HHS issued regulations for navigators' training and conduct.¹⁴⁶ The fact that the navigators are federally certified and monitored has not dissuaded some states from imposing additional requirements. Many of the states without their own exchanges have also enacted navigator-burdening legislation, further compounding the lack of outreach associated with the absence of a state exchange.¹⁴⁷ While a clear causal relationship between burdened navigators and low ACA enrollment is difficult to confirm, some analysis suggests a link between the burdens and lower enrollment.¹⁴⁸

Restrictions have included additional education and licensing requirements, and even restrictions on the content of information navigators can provide. Missouri, for example, passed its Health Insurance Marketplace Innovation Act of

146. 45 C.F.R. 155 (2014). The federal regulation requires

a certified application counselor program. It creates conflict-of-interest, training and certification, and meaningful access standards; clarifies that any licensing, certification, or other standards prescribed by a state or Exchange must not prevent application of the provisions of title I of the Affordable Care Act; adds entities with relationships to issuers of stop loss insurance to the list of entities that are ineligible to become Navigators; and clarifies that the same ineligibility criteria that apply to Navigators apply to certain non-Navigator assistance personnel. The final rule also directs that each Exchange designate organizations which will then certify their staff members and volunteers to be application counselors that assist consumers and facilitate enrollment in qualified health plans and insurance affordability programs, and provides standards for that designation.

Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel; Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, 78 Fed. Reg. 42,824, 42,824 (July 17, 2013) (to be codified at 45 C.F.R. pt. 155).

147. See Justin Giovannelli et al., *Under Pressure: An Update on Restrictive State Insurance Marketplace Consumer Assistance Laws*, THE COMMONWEALTH FUND (Oct. 31, 2013), www.commonwealthfund.org/publications/blog/2013/oct/under-pressure ("For Americans living in states with federally run marketplaces—where consumer outreach efforts have been modest to begin with—this chilling effect only makes it harder to learn about the health law and enroll in coverage.").

148. See POLSKY ET AL., STATE-BASED MARKETPLACES, *supra* note 136, at 3 ("The effectiveness of the Navigators themselves might have differed from state to state, especially in states that create barriers to assister programs.").

2013, which classified all federal navigators as state navigators¹⁴⁹ and imposed stringent state requirements on all navigators. On January 23, 2014, a federal judge in the Western District of Missouri issued a preliminary injunction for these additional requirements, finding them unduly burdensome on the federal law.¹⁵⁰ Under the Missouri law, navigators would have had to obtain a state license (in addition to the required federal license) and comply with continuing education requirements;¹⁵¹ navigators would also have had to become “insurance producers” under state law, which are insurance agents or insurance companies.¹⁵² In striking down the Missouri law, the court pointed out that the Missouri law precluded navigators from performing some functions that federal law required them to perform.¹⁵³

The State of Texas also enacted navigator requirements, complaining in the preamble to its new regulations that the federal regulations were not sufficiently stringent.¹⁵⁴ The Texas requirements were enacted on January 21, 2014, and required compliance by March 1, 2014—with the 2014 open enrollment window set to close on March 31, 2014, the timing

149. In Missouri, a State Navigator is defined as a person who “for compensation, provides information or services in connection with eligibility, enrollment, or program specifications of any health benefit exchange operating in this state” MO. REV. STAT. § 376.2000(4) (2014).

150. *See* *St. Louis Effort for AIDS v. Huff*, 996 F. Supp. 2d 798 (W.D. Mo. 2014).

151. *See* MO. REV. STAT. §§ 376.2002(1), 2004(5), 2006(3) (2014).

152. *Id.* §§ 375.012(6), 014 (2014).

153. *St. Louis Effort for AIDS*, 996 F. Supp. 2d at 806 (noting that federal navigators are required to “distribute fair and impartial information concerning enrollment” in health plans as well as information regarding tax credits, while the state law prohibited navigators from giving “advice concerning the benefits, terms and features of a particular health plan or offer advice about which exchange health plan is better or worse” without licensing as an insurance agent). The court found that the state law obstructed the federal purpose, because the ACA requires HHS to contract only with non-profit entities and those who are not receiving money from insurance companies—requiring that navigators be insurance agents yet not be receiving monies from insurance companies was therefore a “significant roadblock” to the ACA’s implantation and function. *Id.* at 807.

154. TEX. DEPT’ OF INS., COMMISSIONER’S ORDER NO. 2962 (2014), *available at* <http://www.tdi.texas.gov/rules/2013/documents/navadoptionorder.pdf>; *see* 28 TEX. ADMIN. CODE §§ 19.4001-4017 (2014).

left little leeway for navigators to comply and assist consumers during that open enrollment period. The law includes a twenty-hour training requirement, a background check, and proof that the navigator has liability insurance.¹⁵⁵

Four states—Georgia, Missouri, Ohio, and Tennessee—prohibit navigators from advising potential enrollees on the benefits and details of particular plans, even though the federal rules call for navigators to help consumers make informed decisions about healthcare and decide which plan is best for the potential enrollee.¹⁵⁶

The effect of these burdens has been hard to quantify, but some analysis points to the navigator burdens as a reason for lower ACA enrollment in such states.¹⁵⁷

ii. Declining to Seek Consumer Assistance Center Funding and Restricting Advice. Many states are refusing to apply for the ACA's grants for consumer assistance centers that are meant to help potential enrollees understand their options and rights; some states even prohibit non-ACA advisors from helping consumers select a suitable health plan.

The need for information is significant—of those Americans without health insurance, only one in four understands the meaning of terms such as “deductible,” “out-of-pocket spending cap,” or “co-pay.”¹⁵⁸ Those without a college education—the demographic less likely to have insurance¹⁵⁹—were even less likely to answer the questions

155. See COMMISSIONER'S ORDER NO. 2962, *supra* note 154.

156. Giovannelli et al., *supra* note 147, at 2.

157. See POLSKY ET AL., STATE-BASED MARKETPLACES, *supra* note 136, at 3 (“The effectiveness of the Navigators themselves might have differed from state to state, especially in states that create barriers to assister programs.”).

158. See George Loewenstein et al., *Consumers' Misunderstanding of Health Insurance*, 32 J. HEALTH ECON. 850, 858 (2013) (finding that only fourteen percent of survey participants could correctly answer all four questions addressing the basics of health insurance: deductibles, copays, coinsurance, and maximum out of pocket costs).

159. See *id.* at 857.

correctly.¹⁶⁰ To address this health insurance literacy gap, the ACA provides funding for consumer assistance centers.¹⁶¹

Twelve states and the District of Columbia currently have these programs; the rest do not.¹⁶² A Kaiser Family Foundation report notes, however, that even in the states that have adopted them, the programs have not been sufficiently funded.¹⁶³ Although a second round of funding was announced in 2014, this funding was limited, available only to states that had obtained funding in the first round.¹⁶⁴

160. *See id.*

161. ACA § 2793(e).

162. *Consumer Assistance Program*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants> (last visited Mar. 17, 2015).

163. KAREN POLLITZ ET AL., THE HENRY J. KAISER FAMILY FOUND., *MEDICAL DEBT AMONG PEOPLE WITH HEALTH INSURANCE* 1, 21 (2014), *available at* <https://kaiserfamilyfoundation.files.wordpress.com/2014/01/8537-medical-debt-among-people-with-health-insurance.pdf> (noting that “the law authorizes ‘such sums as are necessary’ to support CAPs but only appropriated \$30 million.”). No funding has been announced since 2012, even though the CAPs

are the only entities required, by federal law, to help privately insured people resolve health plan complaints and claims disputes and file appeals. Absent this help, as case studies illustrate, some people may continue to be overwhelmed by insurance paperwork they cannot understand and even incur debt for bills insurance should have paid.

Id. at 21.

164. DEP’T OF HEALTH & HUMAN SERVS., *LIMITED COMPETITION FOR AFFORDABLE CARE ACT CONSUMER ASSISTANCE PROGRAM GRANTS* 10 (2014), *available at* <https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=49797> (follow “View PDF” link).

These grant funds can be used to re-establish, extend, or enhance activities being funded under the 2010 grants. For example, if a Consumer Assistance Program was performing an outreach campaign that included a 6-month public service announcement (PSA) on the radio under the 2010 grant award, that Consumer Assistance Program could extend the PSA beyond the original six months, or add a different PSA. The Consumer Assistance Program could also use these funds to add to the radio campaign through other media not currently included in their project plans, such as newspapers, local magazines, or television. Funds awarded under this grant funding opportunity announcement cannot supplant funding under any prior or future Consumer Assistance Program funding opportunities if grant periods overlap.

CTRS. FOR MEDICARE & MEDICAID SERVS., *CONSUMER ASSISTANCE PROGRAM LIMITED COMPETITION FUNDING OPPORTUNITY ANNOUNCEMENT FAQs* (2014),

Of the states that have not sought such help, many do not have their own exchanges, which further exacerbates the lack of information in those states. That is, states without their own exchanges already lack the outreach that goes along with exchanges,¹⁶⁵ and those same states spend less money on consumer assistance.¹⁶⁶ And, the states using the federal exchange have a far higher proportion of uninsured individuals to begin with than in those states with state exchanges.¹⁶⁷

In the states that have implemented citizens' assistance programs, the results have been promising, and citizens have been helped. The states that have sought and accepted funds have spent them on programs such as consumer education, advocacy, and assistance.¹⁶⁸ With additional millions of dollars, states are able to implement programs providing direct, local assistance to consumers, to inform them of their rights and help them with health insurance issues.¹⁶⁹

available at <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Final-CAP-Limited-FOA-External-FAQ-08-13-2014.pdf>.

165. See *supra* Part II.B.2.a.

166. See POLSKY ET AL., STATE-BASED MARKETPLACES, *supra* note 136, at 3 ("By comparing consumer assistance funds to the uninsured, we found consumer assistance funds to be more concentrated in [state-based marketplace] states. [State based marketplace] accounted for 50% of total consumer assistance funds, although they have just 31% of all uninsured. In contrast, 63% of the uninsured live in [federally-facilitated marketplace] states, which accounted for 33% of the funding. The five partnership states in charge of consumer assistance functions were home to just 6% of the uninsured, but garnered 17% of the funding").

167. See *id.*

168. *Consumer Assistance Program*, N.Y. STATE OF HEALTH (July 22, 2010), <http://info.nystateofhealth.ny.gov/resource/consumer-assistance-program>; see also *Consumer Assistance Program Grants: How States Are Using New Resource to Give Consumers Greater Control of Their Health Care*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://cms.gov/CCIIO/resources/grants/cap-grants-states.html> (last visited Mar. 17, 2015) (noting that New York used the money to enhance the capacity of partnering community based organizations to strengthen their geographical reach, provide more services, increase helpline capacity deepen presentation skills to educate consumers, educate staff about consumer appeals and how to assist with appeals, and strengthen overall assistance to consumers).

169. For example, California was awarded \$4,635,952. Ani Fete, *Consumer Assistance Programs Get \$20 Million from HHS*, ENROLL AMERICA (Aug. 30, 2012, 3:28 PM), <http://www.enrollamerica.org/blog/2012/08/consumer-assistance->

Some states' restrictions on consumer assistance go beyond a rejection of the ACA's consumer assistance centers—Georgia and Illinois place restrictions on individuals and community groups that might attempt to help potential enrollees assess different coverage options.¹⁷⁰ Tennessee's restrictions were so broad that a lawsuit resulted in an agreement that the restrictions would not be enforced so broadly.¹⁷¹

c. *Missing Information for Enforcement.* To enforce the new rules and protect consumer rights, consumers must learn their rights and enforcement officials must know that a problem exists. States are meant to be the primary enforcers of compliance with health insurance market reforms, such as the new appeals process and others.¹⁷² Where the states lack the authority or ability to enforce the provisions, enforcement is left to the federal government.

For example, the ACA provides that individual and group health coverage must provide for external review of denied claims.¹⁷³ The process is complex, and the vast majority of consumers never seek even an internal appeal of a denied claim. Most are completely unaware of any available consumer assistance.¹⁷⁴ To remedy this situation, and to help consumers to understand and progress through the process, notices of claim denial (known as Explanations of Benefits or

programs-get-20-million-from-hhs. It plans to “[p]artner with non-profit community-based organizations to provide direct, local consumer assistance;” “[c]reate appropriate, accessible health care consumer information and resources for seniors and Californians with disabilities;” and “[e]xpand existing resources and training materials for consumer assistance organizations[.]” *Consumer Assistance Program Grants: How States Are Using New Resource to Give Consumers Greater Control of Their Health Care*, *supra* note 168.

170. Giovannelli et al., *supra* note 147.

171. *Id.*; see Agreed Final Order, League of Women Voters of Tenn. v. McPeak, No. 13-1365-IV (Tenn. Ch. Oct. 7, 2013), *available at* <http://www.tnjustice.org/wp-content/uploads/2013/10/Agreed-Final-Order-as-Entered.pdf>.

172. See ACA §§ 2701, 2719; *Compliance*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/compliance.html> [hereinafter CMS, *Compliance*].

173. ACA § 2719(b).

174. POLLITZ ET AL., *supra* note 163.

EOBs) must inform consumers about any available ombudsman or consumer assistance office created by the states under the ACA that can offer help.¹⁷⁵

When the state declines to set up such a consumer assistance center, the information on the EOB then directs consumers to the Department of Labor (“DOL”).¹⁷⁶ The DOL will attempt to resolve the dispute through informal settlement procedures.¹⁷⁷ There is, however, a bias against the federal government’s involvement with health insurance, particularly among Republicans,¹⁷⁸ such that the federal

175. ACA § 2719; 29 C.F.R. § 2590.715–2719(b)(2)(ii)(E)(5) (2014) (“The plan and issuer must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes.”).

176. DEP’T OF LABOR, TECHNICAL RELEASE 2011-01 3 (2011), *available at* <http://www.dol.gov/ebsa/pdf/tr11-01.pdf>.

177. *See, e.g., id.* The DOL offers the following assistance with disputes:

Complaints involving alleged violations of ERISA are handled by Benefit Advisors in our national and field offices. Those who file complaints with us can expect a prompt and courteous response from our staff. Every complaint received will be pursued and, if determined to be valid, resolution will be sought through informal dispute resolution. You can expect to receive a status report from the assigned benefits advisor every 30 days. If your valid complaint cannot be resolved informally, it may be referred for further review by our enforcement staff. While we cannot ensure that every complaint will result in an investigation, at the conclusion of enforcement activity, if requested, we will furnish an understandable explanation of the outcome of our review and investigation.

About the Employee Benefits Security Administration, DEP’T OF LABOR, <http://www.dol.gov/ebsa/aboutebsa/main.html> (last visited Mar. 17, 2015).

178. DROPP ET AL., *supra* note 101, at 15 (“Republicans have significantly less confidence in the successful implementation of the exchanges when told that they will be managed by the federal government. Republicans are more than twice as likely to exhibit confidence in state-run exchanges (43 percent) compared with federally-managed exchanges (20 percent).”). When asked whether the state or federal government should provide health insurance for low-income people, only about a quarter of the people said that the federal government should provide it (24% in Arkansas, 26% in Kentucky, 25% in Louisiana, 27% in North Carolina). The majority said that the state or local government should handle it (46% in Arkansas, 48% in Kentucky, 47% in Louisiana, 47% in North Carolina). N.Y. TIMES & THE HENRY J. KAISER FAMILY FOUND., POLLS IN FOUR SOUTHERN STATES,

government may not to be the source that citizens turn to for information about insurance help. The absence of a state consumer assistance center coupled with this bias against federal help for such matters suggests that enforcement may be hobbled in these states. In this manner, the new appeal process, often lauded as one of the ACA's greatest additions to the panoply of consumer protections,¹⁷⁹ is undermined by lack of state participation. Notice of consumer assistance centers is particularly important, because studies such as the recent Kaiser Family Foundation report indicate that individuals often do not know when there is help available or how to find it.¹⁸⁰

Consumer assistance centers—which, as explained above, most states have refused—do not only disseminate information, but collect it too for purposes of enforcement. Consumer assistance center grants are conditioned upon the entity's promise to collect information to be used for targeted enforcement.¹⁸¹ In these states, then, state officials have less

6 [hereinafter *Polls in Four Southern States*], available at <https://kaiserfamilyfoundation.files.wordpress.com/2014/04/8580-t2.pdf>.

179. Candy Sagon, *New Tools Help Fight Health Claim Denials*, AARP BULL., Sept. 2010, at 4 (“Fighting back when your health insurance company denies a claim just got a little easier, thanks to federal rules recently issued under the healthcare overhaul law.”); Alison Young, *Rules to Ease Consumer Appeals in Health Coverage*, USA TODAY, July 23-25, 2010 at 3A.

180. POLLITZ ET AL., *supra* note 163, at 4 (noting that most individuals surveyed did not know where to seek help and that the “burdens of illness made it harder to resolve problems on their own”). In the Kaiser report’s case studies, person after person reported that they did not know their state had a Consumer Assistance Program. *Id.* at 23 (“[Consumer] did not know her state has a Consumer Assistance Program that would help her file an appeal”); *id.* at 25 (describing a consumer who wrote to his congressman and others for help but did not know his state had a Consumer Assistance Program that could have helped him with appeals).

181. Dept. of Health & Human Service, *Affordable Care Act (ACA)—Consumer Assistance Program Grants, Initial Announcement Invitation to Apply for FY 2010* 3-7 (Jul. 2010) (“[Programs must] collect data on consumer inquiries and complaints to help the Secretary identify problems in the marketplace and strengthen enforcement States must demonstrate that designees can advocate freely and vigorously on behalf of consumers . . . [and] are capable of reporting objective data to the Secretary on the responsiveness of agencies that oversee private health insurance and group health plans and public

information regarding potential problems, and consumers are less likely to know their rights.

The federal fallback remains an option, but can it really be effective? Its role is limited by logistical issues as well as state primacy in such matters—the measured approach to enforcement reflected in HHS’s statements reflects these limitations.¹⁸² The federal government’s approach to enforcement is incremental and careful out of fear of being labelled unconstitutional commandeering.¹⁸³ Even so, the federal government’s role is necessary, given that Alabama, Missouri, Oklahoma, Texas, and Wyoming have all stated that they lack authority to enforce any ACA market reforms.¹⁸⁴

The federal government can enforce the market reforms either when a state indicates that it will not do so, or when it becomes apparent that “a State has failed to substantially enforce a provision” of the ACA involving “the issuance, sale, renewal, and offering of health insurance coverage in connection with group health plans or individual health insurance.”¹⁸⁵ Federal intervention is permitted if a complaint is filed with the Centers for Medicare and Medicaid Services,¹⁸⁶ if news media reports indicate a problem,¹⁸⁷ or if “any other information” indicates that the state is not enforcing the market reforms.¹⁸⁸ One commentator has described this process as “painfully”

coverage There should be staff available to answer consumer calls in real time.”).

182. See CMS, *Compliance*, *supra* note 172.

183. Rosenbaum, *supra* note 104, at 178-79 (noting that “[t]he solution may be messy, but conceptually it hangs together . . . the approach is at least conceptually workable”).

184. CMS, *Compliance*, *supra* note 172.

185. 42 U.S.C. § 300gg-22(a)(2) (2012). The Public Health Service Act explains the Secretary’s and the federal enforcement powers, which can involve civil money penalties and a means for determining liability. Rosenbaum, *supra* note 104, at 180 n.67 (noting that states retain the sole power to act upon the issuer’s license).

186. 45 C.F.R. § 150.205(a) (2014).

187. *Id.* § 150.205(c); see *id.* § 150.101 (providing that CMS has jurisdiction over the market reforms).

188. *Id.* § 150.205(f).

deferential to the states.¹⁸⁹ Even when a problem is uncovered, the process still returns to the state to determine “whether the affected individual or entity has made reasonable efforts to exhaust available State remedies.”¹⁹⁰

The enforcement process itself is equally deferential to the states. Enforcement begins by consulting with the state in question.¹⁹¹ Not only is enforcement deferential and protracted, but it is hard to even find in the first instance. The CMS website provides a lengthy explanation of its partnership with the states,¹⁹² but this is hardly comforting if one lives in a state such as Texas, which has already sworn to resist the ACA as much as possible.¹⁹³ The mere presence of this federal fall-back system, though, may serve a deterrent function of some sort.¹⁹⁴ However, by cutting off information to consumers and declining to accept awards that require the collection of consumer complaint information, the anti-ACA states have lessened the likelihood that any complaints will come to light, or that consumers will even know that they have grounds for a complaint.

189. Rosenbaum, *supra* note 104, at 181.

190. 45 C.F.R. § 150.209; Rosenbaum, *supra* note 104, at 181 (“[E]ven when evidence of nonenforcement surfaces, the regulations throw the matter back into the very state system whose alleged failure is the subject of the third-party evidence.”).

191. 45 C.F.R. §§ 150.211-221 (explaining the process of notice to state officials, a thirty-day wait for a response with an option to extend the time to respond, an initial determination and additional time for the state to show substantial enforcement, and then a final determination as to whether CMS will intervene in the process).

192. See, e.g., *State Health Insurance Marketplaces*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/state-marketplaces.html> (last visited Mar. 17, 2015).

193. See Letter from Rick Perry, Governor of Tex., to Kathleen Sebelius, U.S. Sec’y of Health & Human Servs. (July 9, 2012), available at <http://gov.texas.gov/files/press-office/O-SebeliusKathleen201207090024.pdf> (“I stand proudly with the growing chorus of governors who reject the PPACA power grab. Thank God and our nation’s founders that we have the right to do so.”); Rosenbaum, *supra* note 104, at 182-83 (“If problems are uncovered, CMS notes that it will ‘work cooperatively’ with the state (the same state that notified CMS that it would not enforce the law) to ‘ensure compliance.’”).

194. Rosenbaum, *supra* note 104, at 183.

One of the ACA's foundational principles is that informational transparency would aid consumers by facilitating consumer understanding and enrollment, giving consumers a chance to push back against unreasonable rate reviews, and permitting precise enforcement of consumer protections. Taken together, the rejections of consumer information transparency provisions emerge as a campaign potentially comparable in its effects to the rejection of the Medicaid expansion, yet operating with little fanfare and without the stakeholder resistance that the rejection of Medicaid's expansion has attracted.

III. IMPLICATIONS OF THE STATES' ACA INFORMATION BLOCKADE & POSSIBLE AMELIORATIONS

The ACA's implementation is evolving, and its status changes daily. The full effect of the states' resistance to consumer information provisions will not be known for years, or even decades. Already, however, some implications of the states' consumer information blockade can be seen.

A. *The Federal Fallback Undermined*

In states declining to host exchanges, expand Medicaid, and enforce market reforms, the federal fallback is crucial for individuals to claim the ACA benefits to which they are entitled. ACA provisions involving information dissemination and transparency, such as those addressing creation and promotion of exchanges, enforcement of market reforms, and others, are among those with a federal fallback. But in states where the federal fallback is necessary, citizens are less receptive to the ACA (in part due to a lack of factually correct information about the ACA)¹⁹⁵ and to federal help, thereby limiting the federal fallback's effectiveness.

When the federal government takes over traditional state functions such as the regulation of health insurance and the enforcement of related consumer rights, the states are effectively ceding this ground to the federal government by allowing the federal fallback to apply, thereby permitting

195. See *supra* Part II.B.2.c.

a soft federal takeover of those areas.¹⁹⁶ But in the states that resist the ACA by declining the Medicaid expansion and refusing exchanges, how effective is this fallback likely to be? Will the federal government be able to enter those fields and overcome these states' hostility to the ACA and federal intervention?

The effectiveness of the federal fallback depends in part on the willingness of citizens to accept the ACA and to turn to the federal government instead of their state government for help. State resistance to the ACA tends to follow along party lines—the ACA is very unpopular with Republican voters, who traditionally dislike large federal programs and have greater faith in their state government.¹⁹⁷ In polls, Republicans held much more negative views than Democrats of the ACA, and Republicans also hold more negative views of the federal government itself.¹⁹⁸ Significantly, when asked about their confidence that an exchange program would succeed, Republicans were much less confident about the program when they were told the federal government would implement it than they were when told the state government would do so.¹⁹⁹ Indeed, 79% of Republicans polled professed to be “not too confident” or “not at all confident” that a health insurance exchange would be successfully implemented if the implementation were conducted by the federal government.²⁰⁰ That number dropped to 57% when the program was described as being implemented by the states.²⁰¹ Democrats, on the other hand, were more confident in the

196. Gluck, *Intrastatutory Federalism*, *supra* note 72, at 587 (“At the same time, however, in those states that opt out of the federal program, the federal government steps in to take over what was often previously an area of state dominion (for example, health insurance) and does so in a more subtle way than taking over the entire system at once.”).

197. Bill Barrow, *Obamacare Faces Near-Solid Block in the South*, HUFFINGTON POST (Mar. 30, 2013, 3:53 PM) http://www.huffingtonpost.com/2013/03/30/obamacare-block_n_2985587.html (quoting Republican pollster Whit Ayers as describing the law as “toxic among Republican primary voters”).

198. DROPP ET AL., *supra* note 101.

199. *Id.* at 2.

200. *Id.* at 10, 11.

201. *Id.* at 11.

exchange program when it was described as a federal program—just 24% were not confident it would succeed, with 34% not confident that state implementation would succeed.²⁰² This lack of confidence can lead to further distrust of the ACA and the federal government.²⁰³ That is, Republicans have less faith in federal government to begin with, so by placing the ACA in federal hands, the ACA is undermined from the start and thus less likely to succeed, further confirming the initial bias.²⁰⁴

In addition, the ACA's framing in the public discourse can affect people's perception of the law and the choices that they make.²⁰⁵ A recent Kaiser poll indicates that even in the four Republican-dominated states studied, a clear majority of individuals tend to believe that the government should be responsible for providing health insurance for low-income people.²⁰⁶ Yet about half the people polled in these states did not know or denied that the ACA provides such help to low-income people.²⁰⁷ Despite lacking this crucial piece of information about the law, wide majorities polled in these

202. *Id.*

203. *Id.* at 17 (predicting “increased political polarization and distrust of the federal government”).

204. *See id.* at 4; *see also* Jonathan Bernstein, 1. *Undermine health care reform* 2. *Complain it doesn't work*, WASH. POST (June 28, 2013), <http://www.washingtonpost.com/blogs/post-partisan/wp/2013/06/28/1-undermine-health-care-reform-2-complain-it-doesnt-work>.

205. *See* Amos Tversky & Daniel Kahneman, *The Framing of Decisions and the Psychology of Choice*, 211 SCIENCE 453, 458 (1981) (noting that “the susceptibility of preferences to variations of framing raises doubt about the feasibility and adequacy of the coherence criterion” that the authors had adopted).

206. *Polls in Four Southern States*, *supra* note 178, at 6. In Arkansas, 70% of people surveyed said that the government at some level should provide health insurance for low-income people; and in Kentucky, North Carolina, and Louisiana, 74%, 74%, and 72%, respectively, of people polled said that government was responsible. *Id.*

207. *Id.* at 4. In Arkansas, 52% did not know or denied that the ACA provides financial help to low and moderate income Americans who don't get insurance at work to help them purchase coverage; in Kentucky, 45%; in Louisiana, 56%; and in North Carolina, 48%. *Id.*

states disapproved or strongly disapproved of the ACA.²⁰⁸ In the same vein, citizens of Medicaid non-expansion states state that they favor Medicaid expansion and other key individual elements of the law (when presented in a question as a specific proposition and not as part of the ACA), even as they profess disapproval of the law as a whole.²⁰⁹ This approval of the law's individual tenets together with disapproval of the law as a whole (when called by its popular name) suggests that opinions about the ACA are not based on factually-correct features of the law but are based on other factors.

The exact reasons for this disconnect are hard to pin down precisely, but it may be no coincidence that these same states have some of the highest per capita spending on anti-ACA advertising.²¹⁰ In anti-ACA states, politicians' rhetoric and negative advertising have affected citizens' views of the ACA.²¹¹ According to some, the anti-ACA environment in the anti-ACA states has led some to believe that the ACA has been repealed.²¹² Social norms have been shown to influence individuals' perception of their choices and to influence behavior in a number of different spheres.²¹³

Thus, even though individuals in southern states actually agree with many tenets of the ACA, the negative information is crowding out the factually correct information,

208. *Id.* Arkansas, 62% disapproved or disapproved strongly of the ACA; in Kentucky, 55%; in Louisiana, 59%; and in North Carolina, 54%. *Id.*

209. Michael Ollove, *Despite Governors' Opposition, Strong Southern Support for Medicaid Expansion*, PEW CHARITABLE TRUSTS (May 21, 2013), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/05/21/despite-governors-opposition-strong-southern-support-for-medicaid-expansion>.

210. Niam Yaraghi, *Have the Anti-Obamacare Ads Backfired?*, BROOKINGS (July 9, 2014), <http://www.brookings.edu/blogs/techtank/posts/2014/07/9-anti-aca-ads-backfire> ("The four states with the highest per capita spending on anti-ACA ads are Kentucky, Arkansas, Louisiana, and North Carolina.").

211. Galewitz, *supra* note 27.

212. *Id.* ("We run into people all the time who say, 'I thought the law had been repealed,' because all they hear is their congressman has voted for the 50th time to repeal the ACA.").

213. See CASS SUNSTEIN & RICHARD THALER, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* 34-35 (2009) (noting that people tend to conform their behavior to what they perceive to be a norm—behaviors studied included college students' drinking and tourists' taking of petrified wood).

such that the ACA emerges tainted and is not judged on a factually correct basis.

B. *Forgoing Benefits While Funding the Benefits of Others*

The states that suppress the informational transparency provisions of the ACA are condemning their citizens to fund the healthcare of those in other states while being less likely to claim their own benefits. Citizens of states that reject informational transparency provisions lose out in multiple ways, explained in turn below: (1) by being less likely to claim their benefits while continuing to be subject to federal taxes and the individual mandate's penalty tax, which operate without state implementation; (2) by losing federal funds which would be spent of premium subsidies and cost sharing; and (3) by receiving less value for their health insurance dollar, because their states decline enforcement activities that would strengthen consumer protections. Some, but not all, of the repercussions of the anti-informational-transparency stance are related to the lower ACA enrollment that characterizes these states.²¹⁴ States can reject certain ACA provisions and avoid disseminating enrollment information about the ACA, as described above, but the revenue-raising portions of the ACA and the individual mandate's penalty tax remain applicable in these states, independent of state implementation. In states rejecting the ACA, then, the citizens lose money at several levels—at the state level, when the state does not receive Medicaid monies,

214. States that have embraced the law by expanding Medicaid and creating their own exchanges have seen their rate of uninsured individuals drop by an average of 2.5%, from 16.1% uninsured to 13.6%, compared with a drop of 0.8%, from 18.7% to 17.9% uninsured, in states implementing neither or just one of these measures. Dan Witters, *Uninsured Rate Drops More in States Embracing Health Law*, GALLUP (Apr. 16, 2014), <http://www.gallup.com/poll/168539/uninsured-rates-drop-states-embracing-health-law.aspx>. In states supporting the ACA with outreach and state-run exchanges, enrollment of the previously uninsured has progressed apace. In California, for example, a state with 7 million uninsured (the highest number in the country), more than 30% of those eligible for marketplace plans had enrolled as of March 17, 2014. Galewitz, *supra* note 27. In states openly hostile to the ACA, the situation is quite different. In Texas, a state with 6.2 million uninsured, fewer than 10% of those eligible had enrolled as of March 1, 2014. *Id.*

and at the individual level, when a lack of outreach and information results in fewer citizens' obtaining health insurance and thereby failing to receive the federal subsidies. And, citizens who do not obtain health insurance are more likely to be subject to the penalty tax.

As an initial matter, the non-expansion of Medicaid results in a large shift in funds from non-expansion states to expansion states.²¹⁵ As explained above, however, the Medicaid expansion opposition is softening for this and other reasons. Medicaid expansion monies are, however, just part of the monies that states rejecting the ACA and shutting down related consumer information will lose.

In addition to the loss of Medicaid monies, these states, due to their lower enrollment, will lose federal monies that would have been spent on premium subsidies and cost sharing.²¹⁶ The premium subsidy and cost-sharing amounts are significant—starting at \$5290 per subsidized enrollee in 2014 and rising to \$7900 in 2023.²¹⁷ While a direct link between resistance to informational transparency provisions and lower enrollment is difficult to establish, the anti-ACA states have taken aim at exactly the mechanisms that would

215. States' decisions to expand Medicaid or not results in a large shift in federal funds. One analysis finds that the 24 expanding states will received \$30.3 billion new federal dollars, while those rejecting expansion will forego \$35.0 billion in new federal dollars. Don Taylor, *ACA: Self Imposed Redistribution from Poor to Rich States*, FREEFORALL (Oct. 26, 2013), <http://donalddhtaylorjr.wordpress.com/2013/10/26/self-imposed-redistribution-from-poor-to-rich-states/#comments>.

216. Henry J. Aaron, *States Engaging in Fiscal Madness*, BROOKINGS (Mar. 18, 2014), <http://brookings.edu/research/opinions/2014/03/18-states-fiscal-madness-medicaid-expansion-aaron> (noting that non-expansion states such as Texas lose not only the federal funds they would have received for Medicaid, but must still subsidize the Medicaid expansion in other states by payment of federal taxes). Rejection of the Medicaid expansion itself results in a loss of \$9.2 billion to the state of Texas by 2022. *Id.* The anti-ACA states are generally lower-income states with greater numbers of poor and uninsured people, so this use of the law in this way becomes regressive, disfavoring the poor and moving money to the richer states.

217. "In total, CBO estimates that the federal government will spend \$5290 per subsidized enrollee in fiscal year 2014, rising to \$7900 in fiscal year 2023. This includes spending for premium tax subsidies; cost-sharing subsidies; and, through 2014, related federal financial support to operate the exchanges." James, *Premium Tax Credits*, *supra* note 11, at 2.

increase enrollment and help consumers obtain these subsidies; navigators, for example, whom anti-ACA states have burdened with additional requirements and restrictions, are charged with explaining tax subsidies to potential enrollees.²¹⁸ By burdening navigators, the seventeen Republican-led states that enacted such regulations not only reduced the likelihood that their citizens would enroll in health insurance plans but also that they would learn about available federal tax credits. As explained above, one of the most significant stated reasons for declining to enroll in or even shop for health insurance is cost.²¹⁹ And yet, the majority remain unaware of the federal tax credits for which they qualify.²²⁰ By interfering with the delivery of information about such tax credits, the states are further declining federal tax monies and discouraging citizens from enrolling in health insurance plans. In declining to operate consumer assistance centers set out in the ACA, states are also adding to their citizens' tax burden by failing to provide help in obtaining premium credits on their taxes, as consumer assistance centers are required by law to do.²²¹

The individual mandate penalties will hit harder where campaigns against health transparency have depressed enrollment.²²² Under the individual mandate, individuals

218. ACA § 1311(i)(3) ("An entity that serves as a navigator under a grant under this subsection shall . . . distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits. . . .").

219. ENROLL AMERICA, THE UNINSURED MIDWAY THROUGH ACA OPEN ENROLLMENT 3, 10 (2013), *available at* https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2014/01/Perry_Undem_Uninsured_Survey.pdf (noting that 69% of people who were uninsured did not have insurance because they could not afford it, yet 69% also did not know about available subsidies).

220. *Id.* at 2-5.

221. ACA § 2793(c)(5) (providing that the office of health insurance consumer assistance shall "resolve problems with obtaining premium tax credits under section 36B" of the Internal Revenue Code).

222. To encourage more Americans to carry health insurance, the ACA features both individual and employer mandates. The mandates are tied to penalties for failure to abide by the mandate, and these penalty payments help subsidize the health insurance premiums of lower-income Americans. In addition, the individual mandate discourages both the free rider problem and adverse selection, in which those with greater health problems would tend to enroll, while

must carry health insurance or face a penalty tax.²²³ The individual mandate is the centerpiece of the ACA, as it is the impetus for all individuals to ensure that they have insurance. Certain groups are excluded from the mandate;²²⁴ these total about twenty-three million people who may not have insurance even after the ACA is fully implemented.²²⁵ Large employers too are subject to a mandate, which requires that they either make affordable health insurance available or pay a penalty, starting in 2015.²²⁶ The individual mandate

those without health problems would forgo enrollment, reasoning that they could enroll later without fear of being barred by pre-existing conditions. MCDONOUGH, *supra* note 9 at 121 (noting that “[v]oluntary systems create a ‘free rider’ problem, as some take advantage of services and benefits without contributing.”); Amy B. Monahan, *On Subsidies and Mandates: A Regulatory Critique of ACA*, 36 J. CORP. L. 781, 787 (2011) (noting that “[t]o combat this likelihood of adverse selection, the individual mandate seeks to get everyone, particularly healthy individuals” covered by health insurance).

223. ACA § 5000A. The penalty tax will be \$695 per year in 2016, or one-twelfth of that amount for every month that the person fails to maintain minimal essential coverage. *Id.* § 5000A(c). The Act further provides that the amount of the penalty will increase each year after 2016 by a cost-of-living adjustment. *Id.* § 5000A(c)(3)(D). Starting in 2014, the penalty tax is phased in, with \$95 per adult (up to \$285 per family) or 1% of total income, whichever is greater. In 2015, the flat fee is \$325 per adult (up to \$975 per family) or 2% of family income, whichever is greater. *Id.* § 5000A(c).

224. Individuals are exempt from the penalty tax on the following bases: (1) religious objection; (2) membership in a federally recognized Indian tribe or eligibility for services through an Indian care provider; (3) income below the tax filing threshold; (4) a gap in coverage of less than three months; (5) a hardship resulting in inability to obtain coverage; (6) inability to afford health insurance such that the minimum amount the person must pay for the premiums is more than 8% of the person’s household income; (7) incarceration; or (8) status in the United States other than U.S. citizen, U.S. national or alien lawfully in the United States. *Id.* § 5000A(d)–(e).

225. MCDONOUGH, *supra* note 9, at 109-10.

226. In 2015 and after, large employers must pay a penalty if:

(a) The employer does not offer health coverage or offers coverage to fewer than 95% of its full-time employees and the dependents of those employees, and at least one of the full-time employees receives a premium tax credit to help pay for coverage on a Marketplace; or (b) The employer offers health coverage to all or at least 95% of its full-time employees, but at least one full-time employee receives a premium tax credit to help pay for coverage on a Marketplace, which may occur because the employer did not offer coverage to that employee or because

and its associated individual penalty tax were set up not as revenue-raisers but as nudges to change behavior—namely, to buy health insurance.²²⁷

But, particularly to people with lower incomes, the penalty tax represents a significant amount of money and is a regressive tax.²²⁸ While much of the ACA invites state implementation, the penalty tax does not.²²⁹ It is filed with an individual's annual federal income tax statement.²³⁰

the coverage the employer offered that employee was either unaffordable to the employee or did not provide minimum value.

Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act, IRS.GOV, <http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act#Liability> (last visited Mar. 17, 2015).

227. MCDONOUGH, *supra* note 9, at 256. Because the penalty does not fit any known theory of taxation, commentators tend to view its main goal as affecting purchasing decisions Monahan, *supra* note 222, at 794 (noting that “this type of distribution does not fit within any known theories of the distribution of income tax burden. If it is to survive rational analysis, it must be because of its impact on purchasing decisions.”). Key revenue-raising sections in the ACA are set out in Title IX. Amounts raised range from \$2.7 billion over ten years, *see* ACA § 5000B, which imposes a tax on indoor tanning salons, to \$210.2 billion over ten years, *see id.* § 9014, which broadens the Medicare hospital insurance tax base for high-income taxpayers. The individual mandate's penalty taxes are estimated to raise \$45 billion over ten years, a sum that is not insignificant, but which was not the main purpose of the penalty. Rather, the penalty was intended to mitigate the problem of adverse selection—if insurance companies are required to guarantee the issue of health insurance to all comers, then people who are healthy could decide to wait until they are ill to obtain health insurance. Jeffrey H. Kahn, *The Individual Mandate Tax Penalty*, 47 U. MICH. J.L. REFORM 319, 332 (2014) (“Congress enacted the individual mandate in an attempt to avoid the adverse selection problem and nudge the healthy into the health insurance pools. The mandate accomplishes this by tilting the balance heavily towards buying health insurance for the vast majority of people.”).

228. The penalty tax is regressive in that individuals at the lower end of the income scale pay the greatest percentage of income as a penalty if they do not purchase health insurance. Monahan, *supra* note 222, at 793-94.

229. Morse, *supra* note 116.

230. Kahn, *supra* note 227, at 320. While non-payment of the penalty can be offset against any refund that would otherwise be due, the penalty tax cannot result in liens or criminal sanctions. ACA § 5000A(g)(2).

When the U.S. Supreme Court ruled that states could opt out of the Medicaid expansion,²³¹ the Congressional Budget Office increased its projection of the number of people who would pay the penalty tax associated with being uninsured.²³² The CBO projected that two million more people would pay the penalty tax than if the states were required to expand Medicaid.²³³ In addition, greater numbers of people will be subject to the penalty tax due to the lower enrollment in the states that have rejected Medicaid, refused to create exchanges, and rejected consumer information transparency provisions.

While the state governments may have legitimate reasons for rejecting the approach to healthcare reform represented by the ACA, the ACA is the law, such that even citizens of anti-ACA states have legitimate benefits that they should be able to access. Currently, citizens are extremely confused about the ACA, and this confusion increases as socioeconomic status and current access to health insurance decline.²³⁴

Finally, when consumers lack access to information about enforcement information—as is the case when the states decline to provide consumer assistance or enforcement of market reforms—and states, in turn, are not collecting information about the issues consumers face, then consumers

231. See *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2601-09 (2012).

232. CONGRESSIONAL BUDGET OFFICE, PAYMENTS OF PENALTIES FOR BEING UNINSURED UNDER THE AFFORDABLE CARE ACT (2012), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/09-19-12-Indiv_Mandate_Penalty.pdf.

233. *Id.* at 1. Of those projected to pay the penalty tax, 600,000 have incomes of less than 100% of the federal poverty level, 1.2 million have incomes of between 100 and 200% of the federal poverty level, 1.2 million have incomes of between 200 and 300% of the federal poverty level, 1.1 million have incomes of less than 300 and 400% of the federal poverty level, 600,000 have incomes of between 400 and 500% of the federal poverty level, and 1.2 million have incomes greater than 500% of the federal poverty level. *Id.*

234. As the 2013-14 open enrollment season approached, 59% of people overall knew that the ACA was the law of the land and would be implemented, while that number sank to 42% when only people with household incomes of less than \$30,000 per year were included. *Kaiser Health Tracking Poll: April 2013*, *supra* note 27.

are receiving less value for their health insurance and tax dollars. That is, they are paying, albeit indirectly, for the ACA's provisions, but they do not receive the full value that consumers in more enforcement-oriented states receive.

C. *Rectifying the Information Gap*

Diverse actors, including Congress, federal agencies, state governments, and private health insurance companies, will need to act in order to close the information gap. Legislators at the federal level have long sought uniform regulation in areas that might result in a race between the states to the regulatory bottom in order to attract businesses seeking relative freedom from regulation.²³⁵ These provisions of the ACA are in danger of becoming just such an area, where citizens are not protected unless more uniform laws are put in place, or state governments move to ensure that their citizens receive the equal benefits of this new law. Nevertheless, broad Congressional action to promote the ACA remains unlikely in the near term.

More modest steps, however, could include Congress providing further funds to establish, continue, and promote Consumer Assistance Centers. This would shore up a means of assisting consumers with healthcare literacy, claims and appeals processes, and the collection of information to further enforcement of the ACA's consumer protections. Without

235. The Clean Air Act is one such example. John P. Dwyer, *The Practice of Federalism Under the Clean Air Act*, 54 MD. L. REV. 1183, 1195 (1995) ("Congress's widely repeated justification for preempting less stringent state ambient air quality standards and certain stationary source emission standards, and for creating the mandatory PSD program, was the states' natural tendency to compete in a "race-to-the-bottom" for business. Because of their willingness to relax environmental standards to attract or keep economic development, states could not be trusted to adopt adequate standards."). The credit card industry is another example. When the Supreme Court permitted companies to use nationwide the usury laws of their home states, the states competed to have the least restrictive usury laws, with South Dakota, Delaware and others completely doing away with ceilings on interest rates. MATTHEW SHERMAN, CTR. FOR ECON. & POLICY RESEARCH, A SHORT HISTORY OF FINANCIAL DEREGULATION IN THE UNITED STATES (2009), available at <http://www.cepr.net/index.php/publications/reports/a-short-history-of-financial-deregulation-in-the-united-states> (follow "PDF" link). Credit card companies immediately moved their operations to these states. See *id.*

proper funding, this program cannot fulfill its potential, even with regard to those states inclined to apply for such funds.

In addition, state navigator restrictions must be closely watched to see if they, as implemented, prevent navigators from carrying out their duties. In its most recent regulation, HHS noted that it would monitor state laws regulating navigators and potentially undermining navigators' eligibility and ability to perform their intended function.²³⁶ HHS has, at this time, declined to enumerate all the potentially-harmful state laws and requirements but states that it "has monitored, and will continue to monitor" non-federal requirements imposed on navigators and other assistance personnel.²³⁷

Significantly, however, those groups and lobbyists who advocate for the expansion of Medicaid should also advocate for greater information access so that citizens can access the benefits to which they are entitled. Medicaid expansion is of course a crucial means of expanding access to healthcare. But apart from Medicaid expansion, many more Americans may choose to access existing benefits if only more information were available.

CONCLUSION

Reforming the American healthcare system of course takes time.²³⁸ The ACA should be judged in terms of decades rather than years.²³⁹ Some predict that over the next years and decades, the ACA will in the end be fully implemented, just as Medicaid, passed in 1965, was eventually implemented in recalcitrant states such as Arizona, but not until 1982.²⁴⁰ Perhaps, as with Medicaid, the ACA will simply

236. 45 C.F.R. § 155.210-215.

237. *Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond*, 79 Fed. Reg. 30,240, 30,274 (2014) (to be codified at scattered parts of 45 C.F.R.).

238. EMANUEL, *supra* note 98, at 291 (noting that reform of such a large healthcare system cannot be done overnight or even in one or two years).

239. *See id.*

240. Rosenbaum, *supra* note 104, at 171 (urging a federal fall-back for the Medicaid expansion).

take time to grow in popularity and to be fully implemented in all the states.

Much of the focus regarding the ACA's implementation has been on the refusal of certain states to expand Medicaid, and rightly so. But the consumer information transparency provisions are crucial too—consumers are confused by the ACA and often put off by the negative information they have heard originating from political sources. Misinformation about the law is particularly acute among those with lower incomes and, therefore, less access to health insurance—the people who most need information about their rights under the ACA.